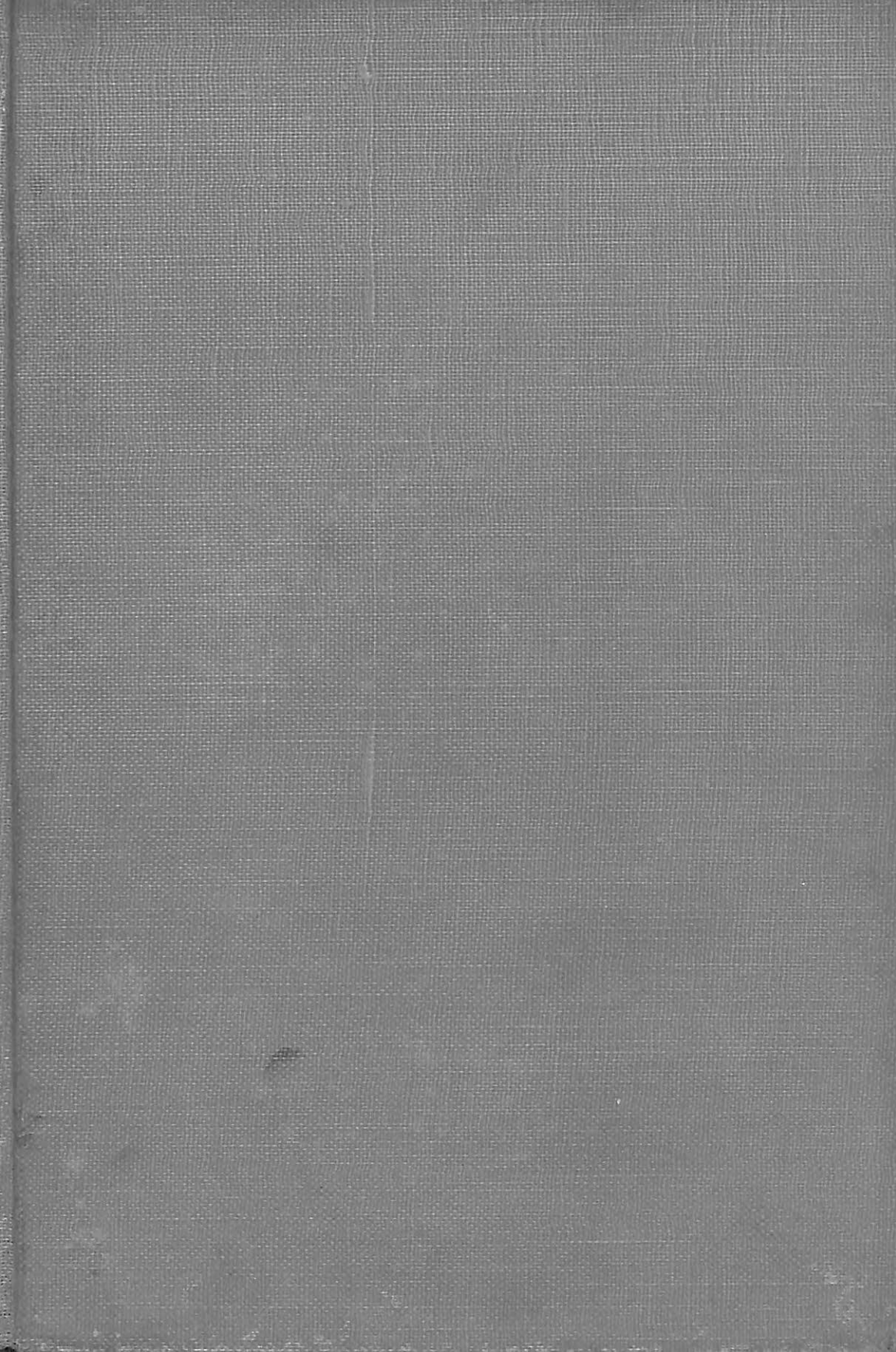




ESSENTIALS OF
ABNORMAL
CHILD PSYCHOLOGY

Dr. Harms is also the author of
HANDBOOK OF CHILD GUIDANCE

ESSENTIALS OF ABNORMAL CHILD PSYCHOLOGY

*A survey representing twenty-five
years' work in the field of
Child Psychology*

by D R . E R N E S T H A R M S



The Julian Press, Inc., Publishers • New York



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Published by The Julian Press, Inc.
251 Fourth Avenue, New York 10
Published simultaneously in Canada
by The Copp Clark Co., Ltd.
Copyright 1953, by Ernest Harms
Printed in the United States of America

966

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ESSENTIALS OF
ABNORMAL
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INTRODUCTION

ON MANY OCCASIONS in the four decades during which I have worked at the study of abnormal human behavior, I have been asked by coworkers to present my views on techniques of diagnosis and treatment. To many people, my application of different techniques in different cases—rather than one predetermined method—seems merely to make the work more difficult. Although the trend in our field, as in all of science, has been to unify and simplify methods, yet it is my contention that the psychological worker must *not* be tied to any routine method, but must rather develop individualized ones adjusted to and often deriving from the individual case.

When I started my study of the problems of mental diseases as a student of Emil Kraepelin in Munich, I was aware of the basic contradiction between the methods of this founder of academic psychiatry and those of the earliest psychoanalytic thinkers. It was evident to me, however, that Kraepelin was only partially justified in his criticism of Freud (126), just as Freud was only partially justified in his denunciations of contemporaries like Adler and Jung, who developed concepts which were somewhat different from his own. I had to accept these differing psychological concepts side by side, because I saw in them the scientific images of a variety of individual psychic structures. Each of these psychological writers represented a specific psychological type which he was, consequently, better able to describe than anyone else. Moreover, I realized that individuals receive the best help from psychotherapists sharing their own psychic structure; and I came to the conclusion that a variety of different concepts, and not any one unified and simplified psychotherapy, is the best means of helping a variety of different people.

Thus, there are two important qualifications which should be required of the psychotherapist: first, knowledge of and insight into the various psychological concepts which have been developed, in order to find the one best suited to the individual; second, a very high degree of empathy into the specific problem of the individual case (92). In the process of helping an impaired adult or child, the therapist should seek empathy to a point where he becomes, so to speak, an unused blackboard on which the patient can write without fear and without the intrusion of the therapists' theoretical knowledge. Only *after* the patient has presented his case should the therapist proceed to inspect the various approaches to diagnosis and therapy offered by the different theoretical schools and find the right one for the individual case (81, 82).

From this it can be understood why I have always been hesitant about writing a general work on the theoretical aspects of diagnosis and therapy, when all my work in the field of abnormal behavior has been intimately connected with practical procedures, rather than with theory. Of these procedures, the most successful and significant have been described in a number of papers published here and abroad over the last twenty years, and it is of these papers, slightly revised, that this book is mainly composed. Part One is concerned with the nature and origins of mental abnormalities in children, while Part Two discusses their treatment and cure.

Part One is primarily an attempt to survey the present field of knowledge of abnormal children, and to evaluate the most important aspects under which such children should be studied. This section begins, logically, with a brief discussion to determine what abnormality can and cannot be considered to be; and proceeds with a consideration of those most important factors in any study of children—parents. For almost half a century analytic psychology has fought the biogeneticism of an earlier age, but little has been said about the problem of the psychological rôle parents [naturally] should play in a child's mental development. I am well aware that my concept of *paternus* and *materna* will be considered a radical one, but it has proved to be of value to me and my students many times over. My hope is that this con-

cept will be expanded as insight into the factors involved increases.

One of the most important problems in the development of modern man is that of his ego. We can trace our modern thinking on this problem from Descartes' formula, "*Cogito ergo sum*," to Freud's ego pluralism—which together form the first arc of a mental bridge which will ultimately carry man's personal and social life, on the trestles of scientifically guided self-control, across the raging depths where lie the sources of crime and war to the safe shore of peace and happiness. I have thought of my studies of the ego problem as contributing to the second span of this bridge, namely, the one which gives us insight into personal and social abnormalities and into the therapy of ego deviations. The chapter on ego inflation and ego deflation is meant as a primer for the student of ego abnormalities.

I have included a chapter on schizophrenia in childhood, at the same time taking a strong stand against the overvaluation of this disease in diagnosis. We once had a period in child psychiatry when almost every deviation of behavior was designated as hysteria (106); we seem to be doing the same thing today with schizophrenia (15, 16, 143). When the diagnosis of schizophrenia is misused en masse it becomes a potential impediment to the improvement and cure of many mentally diseased and also of many misdiagnosed children. Unless better judgment is used, the schizophrenia syndrome may suffer the same fate as the earlier hysteria syndrome: overuse will lead to its being completely discarded. I have discussed the factors involved in both syndromes, and tried to give each its correct and limited place in the total classification of symptoms of mental diseases of childhood.

It is my opinion that we must give greater attention to a third syndrome, that of manic-depressive illness in children—not because it is more frequent or dangerous than hysteria or schizophrenia, but because, while professional workers have been well trained in the understanding of the latter two, knowledge of depressive and manic behavior is almost completely absent. It is possible that the use of the childhood hysteria syndrome is kept alive as a diagnostic tool because of the powerful work done on it by Sigmund Freud, which impressed it upon the minds of

students of Freudian psychoanalysis. There is an almost unconscious tendency on the part of most psychiatric workers to shut out any fact that might lead to the conclusion that the depressive tendencies occurring in nearly every third or fourth child should be dealt with. I have resisted the temptation to study the reasons why child psychiatry has made so little headway in the understanding of manic-depressive illness, and simply presented the factual material dealing with symptomatology and therapy.

To those readers whose thinking is largely directed by the present school of American child psychiatry, the omission of such somatic pictures as, for instance, primary behavior disorders, may seem unjustified. I must here state my conviction that the concept of primary behavior disorders has grown up as a screen to hide the embarrassment of those workers who do not know how to handle certain symptoms. I have never seen a satisfactory explanation of the meaning of this term or justification for its existence. Any of the cases designated as primary behavior disorders can be found to belong to one or another of the major syndromes if properly analyzed. This "omission" has been balanced by a detailed discussion of the more specific mental defects of childhood such as speech and learning defects.

The chapter entitled "The Mignon Neurosis"—to my mind the most important contribution this volume makes to the field—contains a discussion of what I like to term *developmental* neurosis. Up to now there has been no discussion of the basic problem of child growth in the entire literature of juvenile mental disease. Some may respond that there has been very intensive discussion of mental retardedness and mental defects in children, but I can only reply that these discussions do not present those symptoms designated as retarded, as *factors of development*. They are considered pragmatically as inferiority factors "falling below" the "standard" quotient of normality. Being rather skeptical of the possibility of changing the basic thinking of the majority of professional workers, I have begun the discussion of the psychopathology of juvenile development with the specific pathology of the fast-growing child, using the literary figure of Goethe's Mignon as an illustrative example.

In the second part of the book, I have had to use a different approach. Instead of surveying diagnostic and therapeutic methods in general, I have described some of the specific techniques that I have worked with, the results of which seem to justify their presentation to others. It is my own individual selection and opinion which constitute the basis of evaluation in this section; there are, of course, many other techniques, equally or more widely used today, which for personal and theoretical reasons I have not included in this presentation.

I wish to express thanks for permission to reprint in this book material copyrighted by Harper & Brothers, New York, from Arthur Burton & Robert E. Harris: *Case Histories in Clinical and Abnormal Psychology*; and from the journals *Psychiatric Quarterly*, *American Journal of Orthopsychiatry*, and *School and Society*.

Spring, 1953

ERNEST HARMS

Part One

**GENETIC PSYCHOLOGY OF MAJOR MENTAL
ABNORMALITIES OF CHILDHOOD**

I

ABNORMALLY NORMAL AND NORMALLY ABNORMAL CHILDREN

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AT PRESENT, we accept mental illness and abnormal behavior as unpleasant but unavoidable facts of human life, originating—like physical disease—from natural causes. We even expect to encounter a rather high frequency of the milder forms of mental disorder, as for example, nervousness. Such abnormalities are somehow thought to be part of modern life—normal for our times.

Looking back through history, we find very different attitudes toward mental illness. Mental abnormalities were not considered to be related to natural causes even as recently as two hundred years ago. They were either sent by God as punishment for immoral and sinful behavior or were the result of witchcraft. The insane were thought to be possessed by the Devil (or devils) and were considered morally incurable souls. There are primitive peoples who kill or outlaw those possessed by evil spirits, to protect the rest of the community against them. A radically contradictory attitude can be found in sections of the Eastern Church, where the insane person is looked upon as a saint (because he has given his mind to God), and the community has to provide for his earthly existence.

It is very difficult to define what may be called normal and abnormal behavior in different ethnic groups. In the twenties, when I was on an ethnological-psychological expedition for a study of the nomadic Lapp tribes in northern Finland, I had on

my staff a young German psychiatrist trained in the best Middle European school. At first he was most enthusiastic about the work, but he soon became more and more silent and after a week he said, much distressed, "I do not know what you want me to register here as special abnormal traits. These people are all completely nuts. I feel as if I were in a ward of schizophrenics." This is a very radical example of an attitude reflecting total misunderstanding between various social or racial groups—the collective attitude which is reflected when we call our neighbors "crazy" because they do not think and act as we do. It is completely obvious that most of the elements upon which we generally base our judgment of normal and abnormal behavior are not factual or intellectual but primarily emotional. If someone's behavior is markedly divergent from what we consider correct, he is judged to be emotionally and mentally abnormal and, therefore, sick. And, contrarily, those whose behavior patterns coincide with our preferences may be considered normal. Unfortunately, this way of arriving at judgments allows for no differentiation with respect to the unusual and the great. We know that some of the most remarkable individuals, many of the geniuses of human history, have because of their unusual behavior and their extraordinary ways of thinking again and again been marked as mentally abnormal—or even considered insane (96).

Even our present scientific attempts to establish a basic concept of "the mentally normal" have not been too successful as yet (70). The greatest success has been achieved in the area of intellectual capacities. There is practically no one today who has not had the experience of taking an intelligence test. We do not need to describe fully at this point what the intelligence test is (33). It should be emphasized, however, that it does not measure actual individual ability, but only the capacity to take in information according to a pattern abstracted from our modern scientific approach to the world. The intelligence test in essence measures the work ability of the intellectual function. In the mass production of similar psychological tools with which a large number of psychologists have busied themselves in the last fifty years, we have been offered a variety of tests many of which try

to go beyond the limits of the general intelligence test (156). However, almost all these tests aim primarily at measuring the degree of ability to do a specific task, with the purpose of evaluating on the basis of this the degree of general ability. The statistical mid-point between a higher and lower degree of ability is established as "normality."

There has always been a crucial shortcoming in all measurement attempts when they have been applied to children. From the point of view of such approaches to measurement, the child will always appear as an incomplete adult. The child is a human being in a state of development. Since it would be hopeless to describe the complete grown-up human being by such measurements, and even more difficult to separate the normal from the abnormal, many psychologists have accepted the fact that they must abandon the pattern of measurement based on adults and work directly with children. They started to try to establish a descriptive pattern of the various age levels or development stages of children. Theoretical basis is here used not as a quantitative measure but as a starting point in the search for the characteristic traits of the various age levels. This work was started by the German William Stern (167-169) and the Buehlers (30, 31), and was carried on by Arnold Gesell (55-61) and his group, who made use of the skill in psychotechnical methods which has reached its highest level in this country. The attempts of the Gesell group to establish age characteristics for the first months of life and for various stages throughout childhood had originally a genetic meaning. But in the form in which they have become publicized, they have been made into another tool for normative evaluation of the development of the child both physically and mentally. There has been a great deal of justifiable and unjustifiable criticism of Gesell's method. Some have maintained that the characteristics selected for description were not valid for all types of children; others have challenged the correctness of the periodicity selected as the basis for the course of development. But there is no doubt that while this entire concept has its justification, yet too definite a formulation of developmental characteristics to be applied to all children becomes dangerous when it is used dogmatically as a tool for evaluation (156).

Such a tool, in the hands of parents and teachers who are unable to use it with scientific discretion, produces unfortunate results, as was seen when the Gesell books were widely distributed among nonscientific readers (as the result of a powerful promotion campaign by the publisher), and a multitude of parents were upset by the discovery—correct or incorrect—that their youngsters did not live up to the Gesell scale. Misuse creates serious misunderstanding, which in the long run impedes scientific efforts to find sound methods for discriminating between normal and abnormal children.

When Sigmund Freud began his ingenious attempt to reinstate psychological psychology (50-53), he pointed out certain abnormal behavior configurations which proved to be independent of bodily function. The only evidence for his conclusion was the abnormal and pathological, although he certainly had some criteria for normal psychological behavior in mind when he set his goals in working with his patients. Undoubtedly, he realized that it was too difficult to isolate a definite description of it. Freud spoke abstractly of psychic or mental functions like the ego and the id, but he never succeeded in describing them clearly, phenomenologically, as he had done so well with the abnormal aspect of everyday behavior. Many students of Freud who respected his clear thinking on hysteria and other psychopathologies were dissatisfied with his attempt to move from the abnormal to the definition of normal mental life. The most outspoken of these was Carl Gustav Jung. Jung demanded that we establish a basic normal concept of the human psyche and that we define from this the basic pattern of abnormal behavior (111, 113). His famous psychological types (114), based upon the introvert-extrovert theory are developed in this way. However, even the psychology of Jung does not give us a simple and concise description or basic pattern for defining normal behavior in the child. Psychiatrists who work in present-day scientific and educational circles, using any of these methods of evaluation, know *that they actually still cling to the Freudian method* although statistical methodology denounces Freud's way of thinking. We repeatedly hear, "This is still in the range of the normal"; or, "This is not normal"—but what normality actually

is we only deduce from what is not normal. On the other hand, a remark like, "Oh, my child is just a normal child," gives us the key to another idea of normality, namely, that to be "just normal" is not desirable. Indeed it is only those parents who feel that their children are defective or retarded who are willing to have them considered as "just normal." All others want to have their children considered superior, *beyond the normal*.

To me, it is almost abnormal to have to work with a normality concept in the mental health of a child (35). Actually, no such thing as "a normality" of the mind of a child exists—but rather a plurality of attitudes and abilities which vary from child to child and which are bound only by the commonly held ideas of superior and inferior qualities of behavior. Between these lies an undefined average state to which we may ascribe whatever color and nuances we please. To define or to search for an abstract normality of a child's mind is in itself "abnormal."

Having presented the difficulties of clarifying the border line between normality and abnormality, discussed some of the ideas of Freud and Gesell and the criticism they have received, I do not presume to challenge their status in taking a position of my own. I do not believe that I have solved the problem nor do I believe that anyone can solve it alone at the present time. But I do feel that I have attempted an advance in a direction which seems more promising of a proper solution than any previously tried. I also believe that my approach presents practical values for the many problems of psychopathology in children at the present time.

In challenging the problem of differentiation of a "mentally normal child" and a "mentally abnormal child" we must leave the rather abstract approach of most of the well-known previous workers. There is no doubt that its basic concept—that the specific abnormality is the first observed objective fact—still holds true to a certain extent. This approach is, however, only valuable with respect to the psychopathological aspect, that is, for the diagnostic part of the total task. Of course, the designation of these symptoms as abnormal is a problem which can only be

solved on a comparative level. There are mental and personality features varying from person to person which we accept as being within the frame of normality without being able specifically to define them. But there are other features such as, for example, too much activity or restlessness, which begin without any doubt to define the abnormality of the behavior of the specific child. We must, however, accept the fact that what may be decidedly pathological for one child may still be perfectly normal for another. There is no general measure in our field, and we must come to the conclusion that *perfect normality is something perfectly abnormal*. Certainly if we find a child sitting motionless staring into a corner for hours, or a child beating his head against the wall, or biting his own arm, we do not disagree that we are dealing with a severely abnormal pathological child. Abnormality is easily established when based on a judgment that exists for deviate behavior. This judgment, however, is only valid for the diagnostic task.

When we turn from diagnosis to therapy, we begin to approach the problem in the reverse direction, that is, from pathology or abnormality towards normality. Here the Freudian view loses its validity. It is at this point that, in the earlier days of the psychoanalytic movement, Jung turned against the basic Freudian concept, maintaining that one simply could not use as a basic definition of cure the disappearance of pathological symptoms. All abnormal behavior is the expression of an underlying medium. It does not simply disappear but can be transformed into something which we may consider as in the realm of normal behavior. In the sphere of physical activity these facts can easily be seen and understood. A limping foot is cured and the patient walks "normally." A swollen cheek goes down and the face returns to the "normal" configuration. There is not much difference in the mental field. Whether one deals with a nervous tic, stammering, head banging, destructiveness, or restlessness, it is not simply a question of whether such abnormalities disappear but rather whether the functions involved have returned to a functioning which we usually call average or normal. This is our aim in the therapeutic process. Most present-day psychotherapy is concerned only with superficially removing the

specific abnormal symptom. In practical language, "he is cured" means, "he doesn't do it any more." For a more thorough, more thoughtful psychotherapy this approach is not satisfactory. We must be assured that the psychic or mental, as well as the physical, functions involved in any pathology have returned to their healthy dynamics before we can justly state that a cure has been achieved. We cannot at this point present examples which make evident the vast difference in these two approaches to therapy, but we can state that in only a small percentage of the cases treated by the first method has real healing been achieved.

In our attempts to clarify in our own minds our thinking on abnormality in children, we must admit our own weaknesses in judgment which may make us see abnormality because of our own disturbances—where, for instance, the behavior of the child does not respond to our own desires and moods and is therefore considered pathological. The disturbed parent and even the disturbed doctor can produce a whole sphere of pathology which is detrimental to an objective understanding. The only answer in such cases as to why the child misbehaves can be "know thyself." After we have passed through the Nibelung circle of fire of parental rages to get to the reality of true mental pathology in children, we encounter yet another obstacle which exists not in the children who are to be studied and helped but in the minds of those who consider it their professional task to describe and classify what we ought to call these abnormal behavior patterns of children. We cannot but join those who are sincerely disturbed when they find that the same set of symptoms may be given a variety of labels. We know, for example, that the German philosopher Friedrich Nietzsche (108, 141) was diagnosed as having seven different mental ailments; the Swedish dramatist, August Strindberg (155) had as many as eight different labels affixed to his set of symptoms.

Why have we failed to develop a more or less complete and logical symptomatology of child psychiatry? If one has followed the development of this field during the last three decades, one will realize that at the same time as forward-looking child psychologists are attempting to adopt new patterns, certain reactionary groups attempt to dogmatize the old patterns beyond

the point required by scientific unity (121). There is hardly any other field in modern science where the contradiction between routine mechanical thinking and abstract speculation is wider and the struggle more intensive (16, 63). This book has been prepared with the hope that these two approaches can be brought together to work for a clarification of the essential problem. One of the worst hurdles in the development of a solid systematic knowledge in this field is the enormous lack of any intensive psychopathology of childhood (6, 19, 43). The few books in this field are almost completely unaware of the need for a new approach and lack a thorough examination of the actual preliminaries of a systematology of the field. There were certain sound beginnings in the writings of the modern leader of work with the mentally abnormal child, Erich Benjamin (20-22), and other European writers have made a sincere effort to continue along his line (1, 37, 38, 68, 146, 161, 170, 179).

The first task of a real psychopathology of childhood should be the development of the various genetic aspects which would lead to a sociology of psychopathology. We have made only beginning attempts at this work, particularly in the field of childhood schizophrenia. Sociology of childhood has generally been attempted in recent decades from a variety of viewpoints (29), but the systematic consideration of the pathological aspects is still lacking.

II

P A T E R N U S A N D M A T E R N A

*Vom Vater hab' ich die Statur, des Lebens ernstes Führen,
Vom Mütterchen die Frohnatur und Lust zu fabulieren.*

J. W. VON GOETHE

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FREUD'S BIOGENETIC CONCEPT of infantile sexuality (49, 51, 74) and the resulting basic ties to the mother in the early period of childhood was a timely and, logically, a perfectly justifiable application of the ontogenic thinking of the type of Ernst Haeckel which was in its prime at the time Freud started his neuropsychiatric expedition into the underworld of human inner life. The concept of "the soul without a soul" found a rather healthy reaction in the congenial thinking of Freud in his realistic combination of ontogenesis and anthropogenesis as human nature may experience it in the dawn and the early days of becoming a human being.

That was more than half a century ago. The progressive battle against anthropologetic materialism has been won by an army of psychologists applying means and measures of natural science in proving the partially or relatively independent existence of psychological facts or factors and remodeling accordingly the entire anthropologic world conception of the end of the nineteenth century into a psychological and sociopsychological one. Psychologists and psychiatrists have become the most essential human-relations men in most affairs of society up to the fundamental decisions in the Second World War. We have learned to watch our activities and even the dynamic of our inner and social life with "psychological eyes," using scientific concepts

where in earlier periods of human history mythological or religious ideas were the guides. Enormous as this progress and this change must seem, it has not been as great along the line of what is known today as "deep" psychology as it has in the line of psychology which in distinction may be called external. Only slow progress has been made along the lines on which Freud started to build a path through the inner mental and psychic wilderness. The master's ideas, limited by his own philosophical environment, have been far less advanced than have similar basic concepts, for instance those of James or Wundt. A group of well-organized followers does its utmost to keep the "royal prerogative" of Freud's thoughts in its original form without permitting it to adjust itself reasonably to the changing pattern of contemporary thought.

For reasons which have not been determined, C. G. Jung, whose autonomic psychological viewpoint (112, 115, 116) is genetically related to Semon's Mnemenism and Bleuler's Neuropsychology (25), made no elaborate attempt to develop in his sensitive and highly differentiated deep-psychology the aspect of the psychogenesis of the child and its relationship to the biological and social aspect of its growth beyond some early beginnings. If he had, we should be further advanced in the direction in which this paper attempts to form some basic concepts for the deep psychology of the child. Jung's masterly ability to form and describe autonomic psychological experiences would have been an invaluable steppingstone for the development of concepts revealing psychological and educational thinking in the path of psychoanalytical understanding of the ground forces of early childhood. Such contributions by Jung would have been a step forward and away from those conceptions of Freud which must be considered today as more or less historical stages of scientific development.

In making the sex and propagative cycles in human life the center of his psychobiological philosophy Freud has seen in the young child nothing more than the animalistic part of his existence. It is true that this exists, as does the similarity of the human fetus in its early stages with that of lower animals. But Freud has not taken into account the simple biological fact that

a human child has a brain many times heavier than that of any other animal. Also, after a few months of existence it tends to abandon the horizontal position for the vertical, a fact in which anthropologists see the biological background of the mental and social superdevelopment of man. This disposition exists in the first days of life and must be taken into account in the development of a total concept on the biogenetic level, such as Freud has attempted (29).

During the most recent period of child psychology an insipid emphasis and overestimation of the mother-child relationship has developed. There is no doubt that many of these conceptions have their origin in the overestimation given by Freud to the biological relation of mother and child in the subconscious forces active in the period of infancy (53). I have on various occasions advocated more sociologically perfect thinking; for instance, the acknowledgment that the father is of equal importance in the conscious as well as the subconscious development of the child. Dogmatic Freudians will object to this point of view and maintain that Freud especially emphasized the importance of the child's relationship to the father, and the Gorgon's head of the Oedipus complex will be brought forward. Freud, of course, developed, as he need them, concepts and theories of his own and they always fit precisely into the entire picture. The father rôle in Freud's concept is as animalistic as his other concepts. The Oedipus concept is nothing more or less than that of the young bison bull who has to fight his way into the sexual property of the herd of the father bull and to kill him or else split a part of the herd away for his own use.

Naturally we have such animalistic impulses, but *they are not alone*. Biological forces are not the sole root of our existence, neither are they such an intensive and final factor in the total of our subconscious or conscious existence as Freud believed. Biologically considered, all that belongs to the large brain of man, his upright walk, and finally his hands, play an equally great part and, quantitatively and qualitatively, are a hundred times more important than the penis and vagina in his inner and social life.

We do not minimize in any way the part played by the father

and mother in the development of every child; on the contrary, we want to enlarge the importance of this rôle. We wish to show that a child is much more than a mere physical product of a father and mother; there are also social, characterological, and educational factors. It is impossible to understand or to assist properly the sound development of a human baby if we look upon it solely with Freudian eyes. We must not consider a child in its growth from father and mother exclusively from a narrow anthropological viewpoint. A survey of the wider fields of anthropology and sociology makes us aware that the rôle of father and mother is more than the biological one. One of the founders of the study of the human society was Bachofen who showed the entire development of human culture growing from a certain specific interplay of father and mother forces in the social growth representing the stream of human development. He formulated his famous concept of matriarchy and patriarchy as sociological group-forms which have always constituted society. According to Bachofen, early mankind had a group form in which the mother and her matriarchy formed the group pattern; this was the basis for all Eastern society. With the rise of Western civilization it was replaced by patriarchy. The father and mother experience, far above the narrow meaning of sex, was the ground pattern of the structure of society. The father and mother reality is shown to be as elementary for the structure of society as a whole as the sex organs of the parents for the physical birth of a child. But we must realize that without this entire reality of society the birth of even one child would be impossible under the necessary social conditions. Human society is a basic condition for the life reality of the parental forces of any couple, as it is for the growth of an individual child. Society itself patterns the parental forces as they have grown since the dawn of mankind. They are much more than the small realization of an individual pair of parents; they form an archetypical reality which belongs as the social background to the total of human existence.

But before proceeding let us consider the father and mother reality as more or less nonsexual, or rather beyond sexual experience. We all have a definite relationship to our parents which

is very little conditioned by the fact that a sexual act of a man and a woman has brought us into existence and that for the short period of nine months we had a prenatal life inside the mother's body. The meaning of father or mother or both parents in the experience of an adult depends very little on this prenatal episode but rather on later social and educational experience, good or bad, that we have collected. The father-and-mother image, as the term is here introduced, which exists in our conscious and unconscious, has little connection with the seed of the father who made us or the womb of mother who carried us. If we think back in a somewhat mythological manner to the "mother womb" from which we came, we do so only from a negative feeling of shame, a desire to return to the place we came from, because we have done so badly in life. All positive feelings, however, which have woven the picture of an individual father or mother, are our postnatal ones of devotion and thanks to those who have brought us up, or if the feelings are negative, those who gave us such a bad social place in life. Even if we think back physically, the physical hereditary elements in our minds are mostly far from the limited sexual zone and we all tend to take our hereditary relationship as a whole, as does Goethe in the quotation which I have used as my motto. We see the mental character traits and the physical traits together as we have received them from our parents. In our personal experience father and mother mean something very real which is so adult that even religions use the father-and-mother experience as an enlarged and deepened expression of a social feeling of relationship and protection: the "Mother Church," the Pope as father, for instance, among the Catholics, and the idea of the priest as "pater" or father indicate clearly the profound bases of experience which do not have much in common with those presented by the Freudian analytical conception, which, as I have emphasized, may be correct for a very small number of individuals but never for the total group of Western mankind.

So far we have only emphasized the part played by the father-and-mother experience on the wide sociological and historical level and as personal experience of an adult human being. However, another and the most realistic father-and-mother ex-

perience interests us most: that of the child. Having emphasized the previous forms we are now prepared to discuss this in such a way that its real character becomes more evident and the Freudian concept becomes more or less modified in the minds of our readers.

If we go back to the actual biological aspect of human existence, we know that no being, either in the plant or animal world, is born more helpless and in more need of assistance from a human social environment than a child. As he expects food and a certain amount of shelter, just because he is a human child, he needs a certain type of human assistance in order to become a real human being. This assistance, however, does not consist only of animal feeding. The material on the wolf-children seems to prove this fully. The human child needs not only the mother's breasts but something more which I will call the parental human placenta: a certain kind and amount of environmental framing which makes possible the proper physical as well as mental and social development (181).

Mythology has emphatically pointed out the tragic social consequences when a human child is raised exclusively under motherly female or fatherly male influence. We recognize the fatherless Parsifal type, who is a man without masculine personality, and we know the brigantesse, the girl raised by men, without a mother, who lacks female personality and outdoes the gangsters in toughness and cruelty. In our actual life we can not meet this problem of fatherlessness and motherlessness in the psychoanalyst's office but must go to the orphan asylums and foster agencies, where we meet the bulk of those who have been very radically exposed to the handicap of being deprived of the protection of those responsible for their existence. Although not much has as yet been done to give a more definite picture of orphan psychology, those who have dealt with a considerable number of them know that they all show signs of mental handicap, especially in regard to certain security patterns, characteristic of the child raised in its own family. This is clear proof of the definite influence of real parenthood upon the sound development of the human child. Orphanhood offers an especially good opportunity to observe the depth of these father-and-mother re-

lationships. Unhappiness at being separated from his real parents or being sent away because of tragic home conditions is felt more seriously than any grief by a young soul. Those who study orphans know the desperate intensity with which orphans long to discover their real parents, even to the point of taking long trips for this end. I should like to report such a case which seems to me an excellent example of these profound interrelationships.

An American couple, both doctors, realizing that they were unable to have a child of their own, decided to adopt one, and returned from England with a few-weeks-old baby girl of Irish descent whose perfect health and good parentage were assured. Much attention—perhaps too much—was given the little “adopted only child,” so that in her overprotected and overeducated situation she did not develop too well. As she grew older she became more and more estranged from the foster parents who had never told the child that she was not their own. Although she had plenty of playmates from the social sphere of her foster parents, she tried to associate with children from a low-class Irish group living almost half a mile away. As she approached adolescence she developed further character traits of the kind of personality and social type to which she had been attracted from the beginning. Conflicts in the foster parents’ home became more and more frequent, especially with the mother. When the girl was fourteen the foster mother, during a severe crisis, lost her temper and told her she was a foster child. The shock of this news seemed to quiet the child at first, but the next day she stated that when she was grown up she would go to England to find her real parents. After a few days of severe depression, attacks of temper began again, directed now against the foster mother whom she accused of stealing her. In less than two weeks she suddenly disappeared, taking with her a considerable amount of money. The couple refrained from notifying the police. The girl managed to board a ship as stowaway, to land unchallenged in England, and to get from there to Ireland. At the end of two months a letter came from her, asking for pardon, explaining that she had to leave and to find her parents. She said that she had not yet succeeded but that she had found kind people who gave her shelter, and the main reason

for her letter was to ask for money. The foster father communicated with the Irish adoption agency through which he had adopted the girl, depositing money with them and asking them to assist her. Three months later another letter arrived saying that she despaired of finding her parents but that she had found people in Ireland with whom she asked permission to stay since she felt more at home with them than in America.

Cases like this can be found in the records of nearly every foster agency. They make deeply impressive the profound tie of an individual child with an individual pair of parents. Such symptoms, in milder form, are often seen in homesickness which is never so much related to the different environmental factors as it is to the actual family ties. These facts demonstrate the definite psychic relationship of every human being to his parents. We take for granted a physical similarity between a child and his father and mother. Goethe, in the sentence quoted at the beginning of this chapter, gives first place to the law of character inheritance which has hardly been taken into account by our modern educational and characterological psychologists. There is no doubt that it exists, but it has been wrongly sought for and can only be clearly revealed by psychoanalytical procedures since it belongs, to a great extent, to the part of our mental existence which is mostly subconscious.

In speaking of mental inheritance from the parents in every individuality we must view it not solely nor even primarily in regard to certain qualities but as a series of dynamic factors or interrelationship between a child and his parents. Actually the only correct part of Freud's Oedipus concept is that it represents a dynamic, a relationship aspect of the connection between parent and child. Of course, a child is primarily created and borne physically by his parents from their flesh and blood. But this helpless newborn creature is for at least fifteen per cent of his entire life helped, guided and molded to existence by his parents, or at least this should be so. There must be a natural relationship between the child and the parents who have created him, just as there is a physical similarity. A child and his parents fit together naturally like the mold to a statue. We speak emotionally of parental love and child love. If we take them

realistically, as revealed in analysis, we find this natural fitting and this relationship based upon hereditary elements. Of course, one must not misunderstand such facts and must allow each individual scope for individual differences of temperament and even character. We are, in fact, just beginning the study of psychological heredity, which will need certain analytical methods to become a field of genuine scientific advance. However, before we can open up a new field of knowledge, which hitherto has been given over almost completely to mythological ideas, it is necessary to ascertain its existence, to map its frontiers, and to prepare the right technical approach.

Since we offer here a new scientific formula it seems proper to repeat: Each child has a hereditary disposition expressed in the desire to be brought up, educated, and socially adjusted by the father and mother to whom he was born, and he has also certain definite character qualities inherited from them which naturally make him desire to be raised in a familial connection with his parents. Since this is a psychological reality, this disposition in a child represents a reality as universal as thinking or will. We therefore feel entitled to give this relationship disposition in a child a special designation. For the relationship disposition to the father we have selected that of *paternus*, and for that to the mother *materna*. They are comparable to Jung's accepted terms *animus* and *anima* (113). Like these factors of our inner life, *paternus* and *materna* are archetypical in character, that is, they are an inherited psychophysical reality belonging to every human being of the present time. They must be considered as basic elements that have existed during a long period of development of the human race. They represent the aboriginal relationship of a human child to his parents.

Before beginning the detailed study of this *paternus* and *materna* reality, I must mention another side of their historic aspect. The cultural historic implication of "matrimonium" or matriarchy and "patrimonium" or patriarchy has already been described as fundamental social forms. However, we are not as interested in the past as in the present. There are doubtless implications in the sociology of modern life in regard to the family and the father-mother relationships similar to those of earlier

times. I need not emphasize the fact that they not only exist but are much more complicated and therefore much more important than formerly. Even scholarly minds have tried to apply to our days the old Bachofenian concept, even maintaining that we are living in a period of new transition from the "*patrimonium*" to the "*matrimonium*." I hesitate to apply these terms at all to the present conditions of Western civilization, since neither of the two earlier types can be precisely expressed in its real meaning. In present-day urban life especially, the father's part in fulfilling his task as regards his satisfactory response to the needs of his children's *paternus* has fallen so far behind that it almost seems as if the mother is again bearing the burden of the family. Fathers who are absent all day earning money and see their children only for a few moments in the evening and on Sundays and holidays, are indeed socially incapable of being real fathers to their children. However, few of our modern conditions can be compared with what was once a healthy and satisfactory form of human living during those thousands of years during which mankind underwent its stages of cultural youth in the Euro-Asiatic continent. We have already indicated that the present role of the mother in carrying the entire home task of the family influence upon the children can hardly be called a sound one. Indeed certain widespread facts seem even to give Freudian concepts a certain theoretical accuracy, since family experience as a social unit of mother and father with their offspring is almost reduced to a mere sex relationship of the parents. The father is away working during the time when he should be giving his attention and help to the raising of his children. Such conditions may, of course, be those of a passing form of unsound civilization, but they are not a desirable form for perfect family living. Even children, in their definite hereditary desire to be influenced by a factor corresponding to their *paternus*, develop such forms of relationship as can be observed in our multiple living quarters where the doorman, elevator operator, chauffeur, or even the policeman, take over the paternal rôle and paternal satisfaction for the children and often mean more in their infantile world than the real fathers. Similar conditions existed in the late medieval period, when the grandmother or spinster aunt took the

mother's part with the children above the age of infancy, since the real mother was too occupied with almost constant pregnancy and care of the one or two babies. Knowledge of these factors of the present historical setting is necessary before entering into more detailed study. We should also be aware of the actual therapeutic and sociotherapeutic implications of the facts already discussed. We know that all recent progressive programs designed to help in the serious problems of youth—its neuroticism, insecurity, delinquency, etc., make innumerable suggestions as to better housing, food, day care, schools, and even psychological and child guidance procedures. Occasionally education of parents is suggested or improvement of their social or financial status, but seldom as a major remedy the actual reconstruction of the family as the fundamental task of really sane and sound human economics. Unfortunately we believe that we can improve our present social and communal status by external measures such as better food and housing, easier communications, shorter working hours, better leisure-time facilities and more highly developed educational methods. We do not realize that all this will not restore the most elementary relationship need: that of properly bringing up human offspring and of returning our life, in all that results from it as civilization or culture, to its healthy basis. From his biological viewpoint, Freud was right in pointing to sex, if a basic viewpoint is our aim. But we are more than animals. And if we wish to rebuild our degenerated human existence the next steps are the archetypical relationships which rise from one generation to the other. Such are the *paternus* and *materna* relationships. The real task is simply to bring parents back to their human job in regard to the physically and mentally healthy growth of their offspring. We shall attempt here a scientific preparation for this task.

In approaching the reality of *paternus* and *materna* we must take into account their constitutional rôle in each child and the change they undergo in the progress toward maturity.

Of the constitutional aspects of the *paternus-materna* problem, the one concerning the actual differentiation of sexes will immediately occur to the reader. Indeed it is basic, as is the dif-

ferentiation of human beings into the two sexes. There must therefore be a fundamentally different configuration of the *paternus* and *materna* in each male and female child. Since the configuration changes with the development through aging we must correlate both aspects. This makes our description and observation of the facts more difficult, but conditions existing in this as in other circumstances force upon us an acceptance of more complicated observations.

We must, of course, agree that *paternus* and *materna* do not always play an equal part, especially during the first few days of life of a human infant. As long as it has a physical feeding relationship with the mother and her breast, the infant has an underlying monistic attitude. If we are ever able to differentiate the child's expressions during his first twenty days of life, we shall hardly be able to find any clear difference in regard to *paternus* and *materna*. Eino Kaila's (120) important experiments along these lines should be developed. There is no doubt, however, that if there is any total parental relationship, that to the mother will prove to be the dominant one.

We have conducted a series of experiments, which will be ready for publication in the near future, showing that we must speak of an unfolding or awakening of the child's parental consciousness to the degree that he opens up his awareness and experience with environmental realities, general as well as social. We usually see a first maturing of the child's personality and mental life when he ceases to call himself by his first name and separates this name from his ego by speaking of himself as "I." We call this stage, which falls between the ages of two years and six months and four years, the ego maturation. This ego maturation is very clearly and definitely connected with the maturation of *paternus* and *materna*. At the moment the child starts to become an ego-endowed being the dualistic character of his mental setup appears.

Even during the pre-ego period the paternal influence plays a fundamental part in the development of the ego. It can be stated with some justification that during the first weeks of life an infant lives only in a real relationship with the mother. It is the mother who usually takes the most care of her newborn child

during the first weeks and months of his existence. Under normal conditions she feeds the infant from her own breast, and under her supervision the baby achieves his first adaptations to life on this earth. During the first month this adaptation is a purely physiological process, and only slowly does the mental growth and that of the personality develop. However, it actually is—or should be—the paternal influence under which the actual awakening of the ego reality occurs (117, 118). C. G. Jung is the only modern psychologist to point out the fact of mental birth about which there are so many earlier mythological conceptions, either in symbolic or pictorial language. The fatherless Parsifal is the fool without personality in a male sense. The father, after the physical birth of his children, has another task of mating, but this time a mental one, in building up the ego of the infant. Under his mentally creative influence *paternus as well as materna* develops. Of course in our modern, socially confused civilization, these factors do not emerge definitely as they have in earlier periods and in the sphere of rural life. But the results are tragically evident in the neurosis of our present-day youth.

Even in a two-year-old child the interplay of the paternal and the maternal forces can be clearly observed. This discussion cannot present all these factors in detail, but almost every sensitive observer is aware of the baby's different reaction toward father and mother. Of course these factors are not expressed in a definitely circumscribed series of symptoms and the usual psychological terminology can scarcely be used. For this reason only *psychoanalysis and a specifically prepared type of child psychoanalysis can give practical results* under these circumstances. Frequently such symptoms can only be demonstrated by certain attitudes in the child which emerge as a general pattern in his entire behavior, and this is what we are able to offer in regard to the symptoms of the earliest period of life. For instance, we do not find much difference between the general behavior of male and female babies, but we see that all expect the main assistance in the fundamental needs of life to be executed by the mother. There is a demanding and a protection and security-seeking attitude towards the mother. Meanwhile, the father has

a somewhat mythological rôle in the experience of the infant. All that later concentrates in juvenile religious expressions, *i.e.*, final and powerful, limiting or extending influences, is connected with the paternal dynamics. In a sense, Father is God to the infant. In this setting the nucleus of the ego and personality of every child develops, and it depends on the degree to which this setting is properly filled in whether a sound and healthy mind develops in the little body.

At about the age of three, the period when the ego really becomes the self-set and self-powered center of a small human being, there is a short impressive and important period in the child's development in regard to the paternal problem. This period has been very frequently observed in connection with the charm it possesses for many observing and sensitive parents. It is the time when the babies discover their "daddy" is quite an earthly being, and it is most impressive that a clear distinction is made by the little boy and the little girl. Many parents are charmed as well as astonished when the baby girl of three begins to take her daddy not quite so seriously. He is the "funny daddy," the daddy she wants to tease. Daddy is no longer God. Now occurs a kind of infantile conversion which, in neurotic children, often causes a subconscious shock when they discover that the paternal experience has lost its mythological character and approaches the down-to-earth pattern which it takes during the following long period of childhood. Little boys have a similar experience but it does not take the same form as it does in girls: the father steps down from the mythological rôle to that of the great big fellow. He is asked whether he is as great as President Roosevelt, or as powerful as the engine man in the train, or whether he can do all the things seen in a movie or considered unusual, such as piloting an airplane or taming a lion. The boy wants the father to be a great, unusual man; not great like God, an experience clouded with emotional striving, but simply wonderful. And especially "the best and finest daddy of all."

This short intermission period foreshadows a fundamental change in the juvenile attitude which starts when ego maturity is achieved, and with it *paternus* and *materna* actually become a

definite and steady function in the inner life of every child. The boy and girl now have quite a different setting in their *paternus* and *materna* structure which actually is reversed. As might be expected, the *paternus* experience of the little girl has fundamentally the same pattern as the *materna* experience in the boy. On the other hand, in expressing, developing, and satisfying his *materna*, the little boy develops that kind of intimate psychic relationship to his mother which cannot but be considered as a kind of psychic marriage. Meanwhile, he develops toward his father a relationship which tries to make him adequate to his own ego ideal. The boy's male impulses try to visualize out of his own ego ideal, which actually is his *paternus*, a pattern of ideal manliness which he attempts to realize in the father. In earlier studies on developmental psychology, especially in regard to humor and religious impulses in childhood, I have attempted to show not only that every period in human growth has a different pattern, but also that the expressions in regard to various fields of human experience are different. As regards the familial, the most intimate sphere of juvenile experience, *paternus* and *materna* are these patterns which because of their intimate relation to the child's actual existence do not change as much as do experiences in other fields. But they have different behavior patterns in the various stages of development.

In the girl the relationship is reversed. The girl develops her female ego ideal as her *materna*, and it is her tendency to have her mother fulfill the realization of this ideal. Meanwhile she develops a similar psychic marriage-like relationship to her father.

It must be clearly understood that I consider these preadolescent relations as nonsexual either in the actual physical or the wider Freudian sense. They are almost purely psychic or mental. Of course, the preadolescent has definite relationships to the facts of sex life in general as well as to that of his parents. We notice in the child of public-school age the predominant sense of observation and attempts to understand any kind of facts in his environmental world. A child as young as three has often observed the physical differences between the sexes and attempts to understand not only them but also the factors

related to them. This increases with the ability to understand intellectually and the growing forces in his own body which bring the sex organization to maturity after the end of the first decade of life. However, we know that during the school age period children of both sexes have little impulse to approach the wider sphere of emotional and dualistic experience in their own age group. This period is that of monosexual social behavior when boys and girls assemble among themselves and a generally negative attitude in regard to the other sex predominates in the personal as well as the collective relationship. I have repeatedly discussed this fact and explained it by the psychological preoccupation of the child with the development in his own body which makes him averse to a psychological intercourse with the opposite sex. In its place are these *paternus* and *materna* relationships which fulfill in the child his needs in the dualistic psychological sphere of his experience, which is still premature in a "prenatal" stage as concerns actual sex experience.

I intend later to discuss the psychopathological aspect of the *paternus* and *materna* problem. One aspect however seems suitable to be discussed here. It is that of a certain validity of the Oedipus complex in the *paternus* and *materna* problem as we have presented it. We have felt justified in comparing the relationship between son and mother and between daughter and father of this age group with a kind of marital relationship in later life, even if this is now exclusively emotional or mental. There can—and rather frequently does—occur also the other side of the mythological Oedipus situation; the desire to eliminate the father. This happens when the ego ideal of the *paternus* fails to find its equivalent in the father, to a degree creating a deep conflict within the child. The demand to eliminate the contact and even the existence of the father produces a psychic situation similar to that contained in the Oedipus myth. This not only leads to a very one-sided development and an emotionally serious disturbance in the child, but also to a much stronger emotional tie to the mother by an attempt to equalize or compensate the loss on the side of the *paternus* by a stronger development of the *materna*. Because of the predominantly patriarchal conditions in our civilization the factor does not emerge as seriously

in the girl as it does in the boy, a fact which prevailed in old Greece.

With the approach and occurrence of adolescence a new and very radical change in the *paternus* and *materna* constitution of the juvenile takes place. In the period immediately preceding adolescence there is a short intermediary period similar to that observed in the intermission which occurred at the age of three years. The first intermission concerned practically the father and the paternal relation alone. The preadolescent one concerns predominantly the mother. It is easier to understand and to explain in the form in which it appears in the boy. We have described the *materna* form during the pre-school age as a period of psychic marriage with the mother. When the boy attains his own actual maturity, this relationship becomes dissolved or loosened, since the awakened sex impulse now strives toward a real companion of the other sex. The rôle of the mother as well as that of the *materna* recedes considerably into the background, as we shall show later. For the boy, the father retains to a much greater extent the rôle of a model which he had before as ideal. However, he is considered more realistically and more as a social member and head of the family group. The girl undergoes this period quite differently. The father frequently proceeds in the same rôle and is used as a protective image where actual sex wishes cannot be openly expressed because of social standards or because of a conflict with the individual consciousness. Sometimes the father becomes a sort of "good old uncle" image. Where actual love relationships occur, the father is often used as ideal *paternus* image to relieve moral pressure caused by social prohibitions. The change in regard to the *materna* relationship is as negative in the girl as it is in the boy. During this intermission period the girl dismisses her *materna* relationships to her mother who has in most ways played the part of the superego and of a female idealization. The girl's *materna* seems to shrink considerably in favor of her general receptivity for sex preparedness. Trends occur in her *materna* for which there are few parallels in the boy, such as that of jealousy and beauty competition, even competition as to place in the family. The potentialities of both sexes in young people seems to strive toward a with-

drawal of their relationship to their mother. It is one of the great secrets of adolescence which has been little observed and still less studied.

During the actual first experiences of sexual maturity the only direct connection between the *paternus* and *materna* sphere of experience and the specific sexual occurs. Almost every adolescent says to himself: "In this way I was created by my father and mother." I have found many documentary proofs of this experience, especially in pictorial presentations and confessions of adolescents. This psychological event may be a single very short one, but may also become the pattern of a long-drawn-out neurotic state with very unhealthy symptoms. This experience always results in a shock, which is only to a small degree conscious, for the paternal sphere of experience of the adolescent. It seems to be an integral factor in the general attitude of adolescents toward their parents, which must be studied more in detail.

However, before this can be done we must present our differentiation of *paternus* and *materna* in the two sexes. Only after a preliminary description of some of the forms in which *paternus* and *materna* appear can we point out their major differences. The adolescent intermediary period makes it obvious that the *paternus* and the *materna* are not the same in the two sexes, either qualitatively or quantitatively, or, to explain in more detail, the *materna* in a girl equals the *paternus* in a boy; or the relationship between mother and son equals that of a father to his daughter.

Even if the comparison is not quite correct it may help us to understand facts which are not quite easy to explain. The terms extravert and introvert, as used by Jung, may be of help. There is always some more aggressive dynamic in the *paternus* functions and a definite refraining or retaining attitude in the *materna* expressions somewhat similar to the types designated. On the other hand, we must be aware that the general pattern of one sex always colors its total behavior. Therefore a *paternus* and a *materna* of a young man are always more masculine than those of a young girl; and a girl's *paternus* and *materna* are more feminine than those of a boy. There seems to be a greater width in all ma-

terna functions, but in general a male youth has a greater potentiality in both his parental relationships. Finally, there is a great difference in the intensity of the parental functions both together and individually during different periods of life. We have emphasized that firstly the human life starts from a *materna* basis; secondly, a strong influx of the parental dynamics urges forward the ego development of the child; thirdly, the high point of *paternus* and *materna* influence during the entire youth period which seems relatively equal in both sexes is observed during the public school age. A definite new height of the *paternus* and *materna* forces appears in every mature person's life after the middle thirties. This period will be described later.

We shall now continue our description of that period in which *paternus* and *materna* actually reach their critical point of development in the mind of the juvenile. Every educator is familiar with the deep break in the juvenile's earlier relationship to his parents after he reaches physical maturity. The youth has an impassioned desire for independence and a desire to be left alone or to be with persons of his own age. The feeling of being "a new generation" surges up and parents represent the old one. In my earlier studies on the basic constitution of the child I have emphasized the fact that physical maturation is not only a maturing of the sex organs but at the same time the final maturing of the powers and dynamics of the will. This factor explains the adolescents' sincere desire to "get out from under" the authority of their parents. But this is only one angle of the problem; the other seems to lie in the fact that the *paternus* and *materna*, earlier called the psychic placenta of the growing individuality, seem not only to have fulfilled their main task but to be exhausted, at least to the extent of desiring a strong social expression. It seems even as if *paternus* and *materna* are used to build internally on the personality of the adolescent. We frequently hear of cases like the following. A young man had a very negative attitude toward his mother, but he always looked for girls who had a certain resemblance to her. The mother image which he had formed in his mind or rather in his subconsciousness as a suppressed part of his *materna* (as a positive picture of the mother as she should be to satisfy him) is

the driving element for the fulfillment of his sex desires. I once had a patient who actually suffered under this fact which had become a compulsive factor. Even in healthy youths, many especially in the nonsexual but emotional relationship to their girl friends or even wives, desire a certain resemblance to the mother. Similar elements do not appear in the girl adolescent. She rarely wants her lover to look like her father. The girl does not "divorce" her father as does the son his mother during adolescence. The girl continues with the paternal relationship which she has always kept away from the sexual level and the lover actually stands beside the father. The psychological setting of the female adolescence can be easily understood if it is realized that the girl desires a protective agent in the emotional excitements and upsets of love life. The *paternus* of a female adolescent has a differential structure, while the *materna* of the male adolescent has a contracting tendency.

Any adolescent, if wisely questioned, will state that his parents mean something different to him at the end of the teen-age period than they did earlier. The young student has a different "attachment" to his parents and his home which on the one hand is more personalized and on the other is more generally familial. The teen-ager has begun to settle the problems between himself and the world by himself and he no longer uses *paternus* and *materna* and his parents as the medium for this. *Paternus* and *materna* are no longer organs reaching outward; they are social elements turned toward a limited sphere of familial social living and the historical and even archetypical relations that exist in every healthy human being.

Paternus and *materna* may be said to go into a secondary dormant state during the most active years of life, at least in individuals who have a relatively normal social and sexual status. The relationship to the parents is a mixture of social and emotional dependence together with more deeply rooted elements made up from positive memories and socio-ethically embedded feelings of gratitude which our civilization, with its religious structure implants in us. However, after the middle thirties there is a reawakening of the *paternus* and the *materna*, at a time when the more vital sexual and social forces have been calmed down

and the "settled personality" tries to find its adjustment on the down slope of life. Suddenly our parents again become intensely interesting to us, not in a limited personal and emotional sense but in a collective, traditional, and hereditary sense. We suddenly become interested in the family and our ancestors, the past in which we have our part on the tree of life connects us with our parents again. We develop a traditional liking for our elders, our *paternus* and *materna* express an open need to see them—to have a contact with them, and a vital social intercourse. There is more to a serious adult love of parents than most of us are aware of. Analysis of the more sensitive type brings amazing evidence of dependence on the mind of the ancestors in all of us even if we do not show the greatest degree and warmest affection for our aged parents. The more our personal and sexual powers weaken the more *paternus* and *materna* come to the fore, becoming a kind of "spirit" of the family and our ancestors for us, our part in the historic, archetypical development. Sometimes even a compensatory tendency emerges in regard to this later rôle of *paternus* and *materna*. I have seen several cases of individuals who in earlier life fled from any family relationships but who later in life developed an excessive desire for it, as if their subconscious demanded a balancing of unachieved adjustment. These are complicated problems which would need a lengthy discussion. Since we are mainly interested in the problem of youth, consideration of other aspects must be postponed.

Our consideration of the *paternus* and *materna* problem has been undertaken as part of a forum devoted to abnormal child psychology, and it is therefore our task to give at least some aspects of the abnormal symptoms connected with this factor. Since our survey of the normal facts had to be as short as was consistent with a general view of the problem, our presentation of abnormal deviations or psychopathologies caused by them must also be very brief. A rather comprehensive volume would be needed to present in more detail the wider and more differentiated normal as well as abnormal aspects.

It seems best to solve this problem by presenting some specific forms of abnormalities caused by disturbances of the *pater-*

nus and *materna* relationships, exemplifying them by a few characteristic cases.

One of the most specific pathogenic situations in this connection is the negative development of the *paternus* and with it of the ego during the earliest period of life. This author is known to oppose the diagnosis of schizophrenia for all kinds of undefined pictures of mental sickness in childhood. However, if there is a situation which must definitely be regarded as pathogenic for schizophrenia it is that of the situation which we are discussing. Many characteristic cases of juvenile or adolescent schizophrenia, if traced back to their presumable source, will reveal something wrong with the *paternus* setting and the ego development of the child. Such a case is that of the son of an extremely eccentric and egocentric mother who had divorced the father of her son when the latter was not yet two years old, thus achieving the sole custody of the child. She raised the boy in an excessively autocratic way, stating that she would not allow him to develop any of the traits that she hated in the father. Of course she overprotected him and restrained any personality development, including that of free will. The boy was unusually intelligent and was rapidly promoted through his early school years. However, even when he was seven or eight years old, severe disturbances appeared in the form of aimlessness, insecurity, inability to complete any task, and withdrawal from any activity demanding an energetic start and persistence. Shortly after puberty the more serious symptoms of ego disturbance made their appearance, culminating finally, after unsuccessful attempts at psychotherapy, in his being institutionalized as a hebephrenic-paranoid schizophrenic. There is no doubt that the tragic family setting and the complete lack of a sound *paternus* development through frustration by the mother were the cause of this unfortunate ending.

The most characteristic and possibly also the most frequent evidence of psychopathology of the school-age period which seems to be determined by abnormal conditions of the *paternus* and *materna* relationship is the syndrome known as the Erich Benjamin "period of resistance" (22). A study of a great number of cases of this syndrome reveals that familial causes are

likely to be primary factors in its pathogenesis, as we have already shown.

The first case is that of a rather frail boy of eight whose mother is an "active woman in public life," a professional worker with an important job. She married late in life, a former high school sweetheart who is a simple, kind, restrained and uncomplicated businessman. The only child came "accidentally" after three years of marriage, upsetting considerably the plans of this career woman. To the casual onlooker her family affairs appear as well arranged as were her professional ambitions. Actually, however, there is no sincere love for and maternal relationship to the child, which had an excellent upbringing during its first two years. The father is conscious that the boy is "not getting from his parents what he should," and tries to atone by giving him as much attention as he can. However, the situation is completely unnatural, because the father seems to try to take the mother's rôle and the mother adopts the social attitude normally belonging to the father. The boy has had a long series of childhood diseases, including rickets, and therefore demands much attention from his *paternus* and *materna* and corresponding attention from his parents. Since this attention is not forthcoming or, worse still, is wrongly given, the boy, more subconsciously than consciously, has developed a permanent serious attitude of resistance. Because of his physical frailty this has led to specific psychosomatic conditions.

The second case is that of a little girl of nine. She is the daughter of an unsuccessful army officer who is now an insurance salesman except when he is unoccupied because of chronic alcoholism. Our little girl is the oldest of five siblings. The continuance of the series of children was stopped by medical interference after the mother's severe illness. The mother, heartbroken, has tried to keep the family together, but in this she is less successful than ambitious and is a rather tragicomic figure, especially to the growing children who "look behind the scenes." The patient is by nature a rather sensitive child, although toughened by years of hardship. She is relatively healthy and of normal intelligence. She has gone through the usual phases of relationship to the parents in her earliest years,

but her *paternus* and *materna* have become more and more disintegrated from the total of her personality. There was an increasing line of resistance episodes which can be easily understood from our previous presentation. But in this case it did not stop at resistance against the parents and the unfortunate family conditions but developed into truancy and other antisocial acts. Tragically enough, it was for this reason alone that the child was brought to the attention of the child guidance and therapeutic workers. When she appeared in my office she took up a position in the middle of the room, with hands stiffly at her sides in a completely defensive, negative gesture as if she expected nothing good from the world. These two cases are typical examples of serious *paternus* and *materna* pathology in the preschool age.

A more detailed presentation of the various problems of this age group would necessitate a long series of various pathogenic situations, starting with the individual disagreement between one type of child and one or both parents and progressing to general familial discontent as exemplified in our second case. Such differential presentation cannot be given in this introductory paper.

It is much more difficult to outline the problem in the adolescent and postadolescent group than with the younger groups because of the greater variety of pathogenic conditioning attributable to the *paternus* and *materna* problem. However, one pathologic picture closely allied to this problem is the great number of cases of hysteria among this age group. The adolescent tries to get away from parental influence and convention pattern. If such pressure situations occur frequently the subconscious restraint reacts, often quite automatically, with a hysterical attack as an attempt to solve the unnatural relationship. It is tremendously difficult to make parents understand that it is not only best to give the healthy adolescent his way as far as possible, but that especially in hysterically abnormal forms of behavior it is best to pay no attention to these scenes. Of course a great many of our adolescent schizophrenics are products of a wrongly developed *paternus* and *materna* conditioning. However, in almost every case I have been able to study, determinations going back to earlier periods of

childhood could be found. Also in such cases pathogenic elements of the same kind nearly always came to light. *Paternus* and *materna* pathology have a long background of such tragic cases.

A final task is the presentation of the consequences of our study on analytic procedures as they are applied today, either in a dogmatic Freudian or in a more liberal form.

If we first take into consideration the concept of child psychoanalysis according to the Freudian school which has based its procedure entirely upon the theory of infantile sexuality, we shall be forced to impose considerable limitation since our own concept limits the validity of the infantile-sexuality concept. According to that concept, child analysis means unveiling the relationships of the analyzed psyche in regard to these facts. Any investigative or curative process must have an aim toward which to strive, but we do not mean to imply that we wish to replace the concept of infantile sexuality simply with that of *paternus* and *materna* or something similar. If a higher objectivation of the analytical process is possible we would favor it. Diagnostic analysis, if developed into a clearly defined psychological method, must be independent of any definite theoretic aims. In other words, it is unessential whether diagnostic psychoanalysis is used for an investigation of so-called infantile sexuality or the factor designated *paternus* and *materna*. As yet there has been little done to clear this fundamental aspect of child psychoanalysis. Hitherto analysis has been mainly synonymous with investigation, and investigating a certain theoretical fact which is already considered existent. Analysis or psychoanalysis is a specific kind of investigation with a certain specific method and procedure different from other analyses as a chemical analysis is different from a philosophical or philological one. For this we need a concept of "psychic," different from philosophical or chemical. But this "psychic" *must not be* only Freudian libidoism. It must be an autonomic concept and a dynamic one, since without both psychoanalysis would be impossible. Beyond this any concept can be the background of a psychological method of investigation, of those conscious or unconscious to the person analyzed as well as to the professional analyzer. Arthur Kronfeld (129) has been

the only one to see the real importance of these factors.

After a general clearing has been achieved, our procedure must be individualized according to the specific spheres of facts toward which we are directed. Here also we must avoid the misconception of investigating upon the background of a theoretical concept. For instance, routine analysts simply analyze the "Oedipus complex" in a client instead of investigating his mental status and applying theoretical knowledge to diagnosis and interpretation of the material gained. It is hardly possible to bridge the gap between such preconceived concepts and the reality of the diseased psyche without doing harm. Those who are not completely convinced of the Freudian concepts have felt the danger of the methods applied in this regard by his dogmatic followers.

This problem becomes especially serious in dealing with children. If there is any merit in Melanie Klein's (124) impossible attempt at child psychoanalysis it is the insight that *other* than rational means must be applied in child analysis. Her idea of filling children's play with Freudian theoretical concepts was a kind of shadow theater in regard to the task of opening up the real channels of children's neurotic traits as far as they can by any means be brought to the surface of infantile consciousness or general active behavior expression. A child's rational life is a minimal one and any intellectual deductions from findings must be done by ourselves. The less we have to rely upon difficult theoretical interpretations the less we shall be isolated with theories far from reality. We come much nearer to reality with a concept like that of *paternus* and *materna* since we can test these on the real behavior relationships of the child. No matter how we start our analysis, if we take the relationship to the parents as an angle we shall have factual material which can be made the object of any kind of interpretation. In this way psychoanalysis becomes more substantial and more real, and a more objective process of analysis itself becomes developed. We are actually helping forward the psychoanalytical movement if we change from analysis tied to the philosophical concepts of Sigmund Freud to an objective, impersonal method. We are preserving and developing the immortal part of his work by attempting to increase the objectivity of his methodological concepts.

III

CHILDHOOD SCHIZOPHRENIA AND CHILDHOOD HYSTERIA

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WHY IN THE HISTORY of medicine one disease seems to hold the spotlight of attention for a period, more than others, stepping forward like a *prima donna* on this tragic stage, is not always easy to explain. There was the period famous for colitis, and now there is one of allergies. This is true not only in the general history of human disease, but in the history of illness in any special field. We find it in psychiatry and even in its recently first developed subdivision: child psychiatry.

In the period between 1890 and 1915 the major interest of those especially active in the treatment of mental illness in juveniles was focused on juvenile hysteria (106). About 1915, this interest in child hysteria died out as suddenly as it arose, and today this disease is rarely seen in the lists of ills diagnosed. From about 1925 on, another disorder started to become the focal point of interest in the field of abnormal child psychology, the psychosis of schizophrenia.

Many serious workers in the field are, however, convinced that some of the cases diagnosed as schizophrenia today belong to quite a different category of disease. The writer's purpose here is not, however, merely to suggest that the fad of any period may lead to an exaggeration of the incidence of any one disease, but more important than this, to point out that a comparison of the material of the two particular periods in which hysteria and schizophrenia were respectively the most common major mental

diseases, affords many cases in which the diagnoses show a great similarity between the disease factors characterized in one period under the one, and in the other period under the other nomenclature. The confusion found in the somatic symptomatology would seem to indicate that an important task for the student of abnormal child psychology would be to draw a clear distinction between these two forms of mental disorder, which, objectively seen, are doubtless among the most frequent mental diseases of childhood.

There may be raised the objection that the label with which a case is tagged is only a problem of doctor's files. There is involved, however, not only a name, but with the name, a whole method and technique of cure. Thus the diagnosis of a case becomes fundamental in the task of psychiatry, the helping of the diseased individual.

There are two other points which need emphasis before the discussion starts. One of the most important results of recent research in juvenile mental illness is our recognition of the fact that these illnesses have a quite different character from adult forms designated by the same names. They have only a partial similarity, or, as Bender (15) has put it, "the juvenile form represents a definite syndrome which can only be understood by the same line of thinking which leads to the concept of adult schizophrenia." The present writer will also apply this method of approach.

The second point is expressed in the order of this discussion. As the problems of juvenile hysteria are rarely discussed today, the writer will start the study from the broad base which the problems of juvenile schizophrenia have in the present discussion of abnormal child psychology. This does not imply any evaluation of child hysteria as a less important disease than schizophrenia. It is in fact the intention in this paper to show how much overemphasis is given to child schizophrenia as compared to child hysteria, and the underemphasis with which child hysteria has been regarded. The very frequency and seriousness of hysteria as a mental illness in children seems to the writer to justify disregarding the opinion expressed by Kanner (121) (when he designates child hysteria as a minor and schizophrenia

as a major psychosis in the forms in which they appear in children).

For the framing, the characterization, and the discrimination of juvenile schizophrenia, Erich Benjamin (21), Leo Kanner (121), Charles Bradley (27, 28), and J. Louise Despert (40-42) have done most. Each of the first three authors gives a series of symptoms of juvenile schizophrenia expressive of similar abnormalities in each of the major psychic activities. The series of Benjamin reads as follows: *Beziehungs-, Affect-, Sprach-, Willens-, Assoziations Störungen, Halluzinationen, Wahn-Stimmungen und Wahn-Ideen*. (Disturbances of relationship, affect, language, will, and association; hallucinations, paranoid emotions and ideas.) Kanner gives the following series: Withdrawal from the environmental realities, general emotional blunting, discrepancy between mood and thought, delusions, ideas of reference, feelings of being influenced, hallucinations, "queer" performances, and incoherent and irrelevant verbal expressions. Bradley gives the following list of individual traits: diminished interest in the environment, emotional disturbances, alteration of motor behavior, speech disturbances, disturbances of thinking, disturbances of overt behavior, hallucinations and delusions, and sleep disorders. Despert (41), realizing the differential picture in childhood schizophrenia, has used the method of individualizing the characterization of individual typical pictures, which, however, run in general in the line that is given by the other authors mentioned. Thus, one sees that schizophrenia in children is a general or major illness affecting practically the totality of all the psychic functions, a fact also emphasized particularly by Kanner. In this general disorder involving all or most of the individual functions, one observes occasionally, however, that one or the other of these disturbed individuals is able to perform normally again for a short period, a fact emphasized by some observers as a difference between juvenile and adult schizophrenia. This seems to indicate an underlying general function, an actual bearer of the specific schizophrenic illness which produces the abnormalities in the various directions. Can there be such a general psychic function?

In the teachings on abnormal psychology by the academic school from Robert Sommer, Morton Prince (153), and Eugene Bleuler (25) to Arthur Kronfeld (129), and in those by the analytical and individual psychology school of Freud, Jung, and Adler, such a formation-function of the entire psychic activity—designated as the ego, the I, or the self has been again and again emphasized. And Kronfeld, in his huge work on schizophrenia, has laid the basis for the present writer's attempt in a paper published some time ago (71) to show that we come best to an understanding of adult—and too of juvenile—schizophrenia if we see it as a special kind of malfunction of the ego. All that has been said from the various viewpoints in regard to the dynamic factor in the abnormalities produced by schizophrenics points toward the theory that we deal here with a weakening and a continuous dissolving and finally a bursting of the ego structure and the ego function. After the first schism of the inner structure has occurred, its entire activity starts to break up, and we have the characteristic picture of what we recognize as adult schizophrenia.

Let us now turn to hysteria. When, in 1913, Emil Kraepelin (126) wrote his famous treatise on hysteria, the period of interest in it as a specific disease of childhood had nearly come to an end. Kraepelin tried to define hysteria as an emotional disease, of which he found about four major forms. Most interesting of all his investigations, was the observation that hysteria proved to be mainly a disease of the second decade of life. Between 25 per cent and 40 per cent of all his hysteric patients were from fifteen to twenty-five years of age. However, if one surveys the great number of studies (106) and observations made by German, French, and American students in regard to the actual abnormal attitudes of hysteric adults and children, one finds factors enumerated from nearly every field of psychic activity, just as those were found in the enumerations of schizophrenic symptoms as they were cited in the foregoing. We learn of social deviations, of thought, emotion, and will disturbances, we find memory and speech difficulties also. And since the functions attacked by hysteria usually return at intervals to normal activity, we are here, still more than in schizophrenia, entitled to assume the

underlying ground-function of the ego which in specific malfunctioning causes the actual activation of the illness. Also, hysteria is basically a disease of the ego structure and the ego function of the individual psyche. However, there is a fundamental difference in the dynamic direction between the ego malfunction in schizophrenia and that in hysteria. The writer described the character of this dynamic activity in schizophrenia as a dissolving and bursting. In hysteria, this is not the case. Nearly every writer on hysteria emphasizes contracting, laming, or paralysis of this or that function in which hysteria finds its expression. In connection with this disease such a laming of the ego always occurs, showing its effect in any individual function, either of the body, as a conversion symptom, or as a purely psychic reaction. Hysteria is always such a contraction or laming which may be either total or partial. It appears in most cases that the ego functions as such remain intact, but are interrupted in their normal execution in spasms of short or long duration. In rare cases only this interruption appears in a sort of stupor for a longer time, or in partial disfunction as in hysteric blindness or stuttering, or even mutism. But after this cramping and laming is removed, the ego function works again normally for the most part. Herein lies the chief difference between the two diseases: In more severe cases of schizophrenia, the ego function seems to be severely hurt and even destroyed and does not regain its normal activity without an extended therapeutic procedure, if it can be restored at all.

The writer has, up to this point, described the theoretical basis upon which it seems to be possible to give a clear insight into the structural and dynamic differences of schizophrenia and hysteria and of their juvenile forms. It will now be the task to show how both types of sickness appear in their pathogenic aspects, because—in this way—it will be possible to apply the conceptions presented here to show their importance for treatment of the juvenile forms of these diseases.

Erich Benjamin, in his textbook (21), has expressed the viewpoint: "If one wishes to consider hysteria as a disease of its own, one ought to extend the content of its meaning infinitely, since there already exists in nearly all normal babies such a mass of

different symptoms which must be considered hysterical." Because of this widely spread appearance of hysterical symptoms even outside the sphere of any real pattern of sickness, Benjamin felt entitled—as he puts it—"to retire from the use of the word hysteria as a specific disease." Benjamin, however, has been one of the first to nominate childhood schizophrenia as a major juvenile mental illness. And he has, indeed, defined a good many symptoms in such a way that they fit into the rather unclear picture of the present overestimation given to childhood schizophrenia.

The present writer has made it the task of this paper to clarify the difference between schizophrenia and hysteria especially in their juvenile forms. We know that in its prepathological state schizophrenia has been solidly built upon the schizoid type presented in his typology by Ernest Kretschmer (127). There is no doubt that this theory is to a great extent responsible for the rather too broad extension of the concept of schizophrenia. Such statements as that quoted from Benjamin, together with the popular, though often incorrectly applied, concept of hysteria, seem to suggest an addition to Kretschmer's typology. Since the days when this theory became known it has occurred to the present writer to wonder whether we have not a right to postulate a hysteroid type similar to the schizoid type and founded equally upon specific physical traits. However important the implications of a hysterical type may be, this discussion must limit itself to merely pointing toward its existence.

On the basis of a theory of hysteria and schizophrenia as expressions of abnormal functioning of the ego, what are the characteristic hysteroid and schizoid—that is to say prepathological—behavior patterns in children? First let us give a characteristic example of schizoid behavior: A child sits at the door or window waiting for hours for his father or for a playmate, but the minute the longed for individual comes into sight the child runs excited and even frightened into the back room or shuts himself into a closet and can hardly be persuaded to come out again. Actually such behavior is not yet at a point to be considered pathological, but it is abnormal. It is explained by the fact that the child has overstrained his ego in expectation and is afterward unable to

make the immediate social contact. What is happening is a dissociation in the functioning of the ego which characterizes schizoidism in children. Next, let us view a typical hysteroid pattern recognizable by all who have to do with children. The child who does not get what he wants often responds with uncontrollable crying spells, fits of kicking, or a stiffening of the arms, or of the entire body. This cannot be called a pathological behavior pattern, but it is an abnormal one. Its explanation is that it is pre-hysterical, hysteroid, or as Benjamin has called it, "hysteria-form" behavior (20). It is caused by the contracting, cramping and laming of the ego; and while this process may release the individual in uncontrolled manic-like actions, it appears to be an actual short-term paralysis of some sort. Thus, although they are expressions of the same ground-function, the two types of abnormality are, in basic character and fundamental dynamics, profoundly different.

There is only a narrow, though a deep abyss between schizoid and hysteroid on the one side, and real schizophrenia and hysteria on the other. And this is especially true in the juvenile forms of both diseases. The attempts of Tramer (177), Bradley (27), and others to trace—through a historical, diary-like survey of a child's development into a schizophrenic—the earliest symptoms of the disease, have up to now proved unsuccessful. And from the theoretical viewpoint presented here, it is easy to understand why this is so. Each individual study of the early stages of schizophrenia will disclose different pathological symptoms which can be reduced by a single somatic common denominator if considered as expressions of an ego-weak and backward individual. Keeping in mind the explanation which sees the fundamental cause of schizophrenia in the dissolving of the ego, one sees in the individual different symptoms with various expressions which are determined by the specific circumstances and which do not always seem to be related to any specific function. One must further take into consideration the fact that the ego function does not mature in a normal baby before the third year of life, when he stops calling himself by his own first name and begins calling himself "I." It seems to the writer, at any rate, rather difficult to find specific indications of juvenile schizophrenia be-

fore this time. However, a retarding of the general functions of speech—so closely tied up with ego development—and the appearance of destructiveness in play activities may be considered an indication of a start of mental illness. They should, however, not be taken as specific symptoms of an incipient schizophrenia, but as part of a much broader framework inclusive of many other forms of illness. However, if after the age of three and even four, the "I" reaction does not appear and echolalia in excess becomes apparent, one must take into consideration the concrete disposition for later schizophrenia. However, such symptoms seldom appear alone, but rather in combination with other retardations in adaptation to the most elementary living habits and with slackening of motor coordination. At times, a child with such symptoms will show a quite normal, or even a rapid, intellectual development, which, however, must not be taken as a specific measure of the status of the child. His ego, which in its natural intellectual maturation at about the age of four is most strongly occupied with the development of the intellectual functions, may in its weak and even pathogenic state tend to express itself in these same intellectual functions. But one will find other symptoms showing serious lack of coordination in such children. Such pathological intellectuality, moreover, is evidenced by persistent questioning in regard to personal security, personal health, and relationships to the environment. Such children express, even in their rather overactive intellectuality, an illness easily observable by the trained eye.

Because of this unhealthy, prodigy-like intellectual glow, a kind of hot-house overgrowth is frequently incorrectly estimated; and the earliest schizophrenic expressions are in many cases overlooked until about the seventh or eighth year of life, when regression sets in. The child of this age is no longer the tireless intellectual question mark, but a simmering bundle of personality impulses and of emotions. The ego now takes on broader functions. It not only motorizes the rational development and keeps the rest of the quick-growing forces going, but it now starts on its task of coordinating the various forces of the individual psyche. At this point one becomes suddenly aware of the dissociated individual of the many case stories, for instance of those which

Despert (41), Rapaport (157), Potter (149), and others have reported. There is actually a dissolved, or more specifically stated, a badly developed ego, which appears to be the basis of the malcoordination, of the retardation of the entire psyche or of major parts of its expressions.

There is a fundamental difference between this preadolescent schizophrenia and that which one rather frequently comes across as starting in postadolescent youth. In the present writer's conception of individual development, it is not until the period of physical maturity that the ego becomes sufficiently rigid to stand as an individual structure with a specific control of will and affect. Schizophrenia which appears or comes to an outbreak in this period has actually to burst this finally installed and matured ego. If one considers schizophrenia as a bursting of the ego, it cannot be found before this period. Before adolescence, schizophrenia is more or less a dissolving of the unfinished ego structure or its crippling in development.

Schizophrenia which breaks out during the second decade of life, already follows the pattern of the disease found in adults. It seems as if physical maturity is the actual dividing line between what one might call a juvenile and an adult form of schizophrenia. Of course, forms of infantilism occur frequently among the cases of postadolescent schizophrenia, especially in cases where the disease has been of a lingering character, and has been carried over from an earlier period, without coming to an actual outbreak or to clear outward appearance until after adolescence is reached. But close as is the resemblance between preadolescent and adult schizophrenia, they differ profoundly, one from the other, as regards therapeutic considerations. There will be a brief discussion of this later.

One may now turn once again to hysteria to study its pathogenetic development. Keeping in mind the writer's early mention of Benjamin's concept, he would like at this point to add another, taken from what appears to be probably the best study of the genetic aspects of juvenile hysteria, that of the Frenchman, George Madin (106). Madin has based his explanation of juvenile hysteria on Janet's general concept of hysteria, a concept which proves to show a curious overlapping with the most fre-

quently mentioned concepts of schizophrenia. Janet speaks of hysteria as a "*dédoublement du conscient et du subconscient*." Based upon this, Madin has tried to explain hysteria as a kind of dissociation phenomenon of the consciousness. There is the striking similarity between the definitions of the two major diseases in the two periods when first hysteria and then schizophrenia held the center of the psychiatric stage. This was due perhaps as much to the fact of real resemblances in the actual individual disease symptoms, as to some confusion or lack of final clarification in terms as well as in theory. Considered, however, from a theoretical viewpoint, such as that presented here, the resemblance no longer exists. One can, of course, describe hysteria as a dissociation of the healthy part of the psyche from the part which is made the object of the disease. But this dissociation is not the essential element in the somatic picture presented by the usual case of hysteria. If both illnesses—schizophrenia and hysteria—are considered to be different forms of pathogenic functioning of the ego, it is the dissociative element which is most characteristic of schizophrenia, and it is the factor of contraction, cramp, and laming which is the essential characteristic of hysteria. In this aspect, one comes to a clear separation of the syndromes of the two diseases.

This fundamental difference is found only too clearly expressed if one steps from hysteroid elements to the earliest forms of hysteria in childhood. While weakness or absence of the ego function were noted as characteristics of the earliest symptoms of real schizophrenia, one finds the opposite in hysteria. The ego functions, in hysteria, appear to be overdeveloped, so that they are disturbingly strong, are not fitted to be tamed and are unable to coordinate. They flow too strongly as a stream in the consciousness and come into conflict with part of the experience of reality, leading to some kind of "mental constipation" which finds expression in contractions, cramps, and outbursts. We all know the violent infantile scenes in which an unrealistic demand expresses itself in an agony of desire or of refusal.

During the second period of juvenile development the problem of hysteria becomes more complicated because of a phenomenon to which Benjamin (22) has devoted considerable

study. He has formulated for this phenomenon the term "*Trotzperiode*," period of resistance, to apply to children of from four or five to eight or nine years. The need for inner independence develops a natural wave of strong resistance against any unwelcome influence and frustration from outside. This, together with an overdeveloped ego, may force parts of the personal dynamics either to outbursts or to contractions and lamings. This "*Trotzperiode*" hysteria is the most characteristic form of juvenile hysteria. Kraepelin (126), as well as Bleuler (25), has emphasized that, in all hysteria, strong emotional elements are involved. This is especially true in this second period of juvenile development and its hysteria pattern. Educational psychologists have designated this second period of juvenile development as that of the maturing of the emotional forces and those of the personality of the child. It is, therefore, no wonder that negative emotions rise easily when resistance becomes incited and that hysteria breaks out with great violence when cause and disposition give the conditioning. Reviewing a number of hysterical patients of this age, one is confronted with a type of sensitive, even hypersensitive, youngster who finds it difficult to manage the ego in regard to strongly developing emotions. If such children have weak ego functions, they become schizophrenics; with unbroken ego functions they become hysterics.

Most preadolescent hysteria is evidenced in scenes of no great violence, though organic attacks of stuttering, mutism, or blindness may last over considerable periods. Attacks are most violent in juveniles during the period of adolescence and later. This is easily explained by the fact that only in adolescence do the functions of will and affect-control become fully developed in connection with sex maturation. Ego malfunctioning of the hysteric type—which makes these young, just matured functions of will and affect its medium—has here, of course, an instrument which hardly could be better suited for violent outbursts. And, in addition: The entire range of sex antithesis which enters the action field of postadolescence hysteria at this point contributes a good deal of motivation. However, it is not true that this is the fundamental element in these attacks, as is maintained by some. The present writer declines to overestimate the factors of sex rela-

tionships and wishes to give the strongest emphasis to importance of the ego functioning as the background of sex hysteria as well as of any other form of this disease.

Postadolescent hysteria, as it has been outlined here, is, however, also distinguishable from all adult forms of attack through one element which the writer wishes to emphasize. These juvenile attacks have a more general character, they are more impulsive attacks, often affecting the entire personality. This is because the ego in teen-age persons is more elastic and vital than in adults. The hysteric attacks of older persons have a certain conventional form which makes them even predictable. Each attack of teen-age hysteria is a case in itself, usually subconsciously conditioned, often even unrealized by the person in whom it occurs. Older hysterics generally are rather aware of their conditions, are even so conscious of them that they can use them, with the exception of such cases as involve amnesia.

Case —

This case history is an illustration. G. was a nineteen-year-old boy, when the writer first learned of him. Both parents, highly neurotic and completely unfit to raise children, had tormented themselves and their two children (of which one was two years younger than the patient) until mother and both young persons were ripe for the psychiatrist. Of poor origin, the family had attained considerable wealth, and the patient was kept in a separate household. His history revealed him as a neurasthenic child from his earliest days. The usual fear elements had been injected by a maid who shut him up for hours in a closet and frightened him in other ways. Washing inconveniences in the poor early home proved to be the basis for a later aquaphobia. The intelligence of the boy showed an astonishing height before and during the first four years of school. He had an I. Q. of between 130 and 140. However, he seemed to have been even at that age hypochondriacal, difficult to handle, and extremely selfish.

At about the age of thirteen—presumably caused by an unrevealed sex attack during a stay in a summer camp—a pathological development set in. Symptoms were withdrawal, permanent refusal to undertake his usual activities, elements of amnesia,

the dropping of the I. Q. in two years to about 80, extreme masturbation, sleeplessness, refusal to speak, to eat, and to make simple social contacts. There was nothing in the picture of the soma of this boy at the age of fifteen that would not lend itself to diagnosis as schizophrenia. The boy was, indeed, ferried about between the offices of psychiatrists and private institutions with the label varying from major behavior disorder with schizophrenic traits to a definite labeling as a full-fledged case of schizophrenia. During a short stay in a public institution, he had the opportunity of seeing all types of psychotics, especially schizophrenics. He adopted not only the behavior pattern of one type, but practically of all. So when the present writer came to observe him, he exhibited catatonic features. How astonished the therapist was to find he had become a hebephrenic when he saw him the second time.

At most times, one would quickly have made a diagnosis. However, this change of disease pattern was somewhat suspicious. Added to this, G. was amazingly observant, missing nothing that happened, and later putting his observations to use to better his situation. In general he presented a stupor pattern, doing most things only under pressure or the threat of discomfort. Letters, which he wrote only with annoyance, indicated no characteristic schizophrenic breakup, but only retardation and a limited thought range. But this, too, was only an expression of his desire not to be bothered. The apparently schizophrenic features proved to have been assumed in a hysterical defense. He used the schizophrenia pattern as an easy mechanism for his hysteric crampings and lamings. The boy had developed a stuporous hysteria, withdrawing from a disagreeable environment, but he was not a schizophrenic.

This case is highly instructive in distinguishing between the two forms of illness. Somatic pictures of a specific illness made inductively from observed symptoms are not alone a proof or are not perfect proof of the presence of a disease, if the symptoms are not permanent in character. G. had observed and learned the attitudes most effective in obtaining what he wanted from those around him. So he imitated severe schizophrenic symptoms. This always worked up to a point until his caretakers got tired of this

pattern and demanded that "he finish this game." He then took on another series of attitudes: a characteristic stupor form of hysteria.

In following the concept of a dissolved ego as the basis of schizophrenia and of an inadequate, strong ego as that of hysteria, one will not make such mistakes of misinterpretation as happened in this case of G. It is known, first of all, that hysteria cannot occur in a schizophrenic individual who lacks the resources out of which to furnish the power and dynamics for hysteric attacks. The contractions and lamings produced by certain individuals in hysteria attacks cannot be produced by schizophrenics. Instead of these, they produce catatonia. Catatonia, however, is not an expression of tension or overtension as hysteria always is, but is a sign of inability, through the nonfunctioning of the dissolved ego, to express normal attitudes.

On the other hand, one may find schizophrenic symptoms in cases of hysteria, as the writer did in the case reported. Schizophrenic symptoms may occur in severe hysteria cases in periods of exhaustion following a series of attacks. The weakening individual whose ego becomes exhausted may become schizophrenic. However, such cases usually cease to be hysteric before starting to develop into a real schizophrenia. During recent years, the writer has observed several cases of hysteria—all in preadolescent girls—which evidenced at times schizoid and at times schizophrenic traits. Further intensive study of the developmental patterns of juveniles falling from hysteria into schizophrenia seems to the writer to be necessary before any final conclusion can be reached as to the extent to which hysteric attacks or a developed hysteroid disposition predisposes a child to schizophrenia. About this, as about many other phases of the problems of juvenile schizophrenia and hysteria, we are still only at the beginnings of satisfactory knowledge.

Let us finally outline in brief the application to therapy of these concepts of schizophrenia and hysteria as based on ego functioning.

Particularly as regards schizophrenia, this concept suggests important changes in the therapeutic measures most commonly

used today. Schizophrenia in this concept implies a need of reconstruction of the ego functioning and of strengthening the ego to such a degree that it may be active in coordinating and directing the other psychic functions of the individual. Shock treatment, of course, does not in any case, consider this aspect. Any therapeutical approach must be sure to take into consideration the question of which functions are still intact and which are in need of reconstruction, or, in the case of juveniles, which are capable of development.

As regards hysteria, changes in therapeutic measures are also suggested by the concept of a basic ego malfunctioning. Hysteria therapy has mostly consisted of loosening tension and of lessening the tendencies to attacks, a therapy actually affecting the ego function without being aimed at it. If hysteria therapy is consciously directed toward correcting the ego functioning, the therapist will avoid the danger of the destruction of valuable inner forces in the sick, and he will be better able to safeguard hysterics in a shortened and intensified cure. The main effect of this orientation, however, will be in the finding that hysteria has been in many cases the real illness, which, incorrectly diagnosed, has been wrongly treated. The writer believes that in unclear cases of children, especially between the ages of ten and twenty no harm will result from an attempt at a hysteria cure. If another ailment is involved, the true character will become apparent under this treatment and it will be possible to come to a clear diagnosis and to adopt an appropriate therapy. Any careful hysteria therapy, effecting tension release, will never do harm, even if applied in cases where other means later on prove to be eventually necessary. Much modern release therapy is aimed primarily at hysteroid or hysterical difficulties from an instinctive realization of the need, but without a clear insight into the real pathological background upon which the disease arose.

IV

EGO INFLATION AND EGO DEFLATION

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IT IS ONE of the most fundamental characteristics of the human mind that it organizes its perceptions as well as its conceptions of knowledge in a contradictory form. We distinguish and organize our perception of color under light and dark; of sound under loud and soft; of sensitivity under warm and cold, etc. Our thinking works on a basis of true or false, exact or inexact; our feelings on happy or unhappy, gay or sad; our will on strong or weak, good or bad, etc. There is no field of human experience and no logical or categorical system of our knowledge in which we do not find this principle or category of contradiction helping us to understand the actions and reactions of our existence.

It is not surprising therefore that in psychology, and especially in modern depth psychology, this principle of contradiction has found basic application. Wherever such psychological theories have been formulated more definitely and more acceptably, such contradictory conceptions have been introduced. Alfred Adler (2, 3) has used them in his generally accepted theory of the inferiority and superiority complex as has Jung (114) in his psychotypology based upon introvert and extrovert. The importance of both these concepts lies primarily in the manner in which they define two contradictory deviations from a normal pattern of psychic existence. Both view our psychic existence from different angles according to the basic viewpoint of the two psychologists. Adler's (5) aspect, for instance, is the relationship of the individual to the total of the outer world. Jung, on the other hand, is interested in the aspect of the psychic structure of the individual as it is exposed to any outside experience (47, 183).

Progress in science means that new data are discovered or that new applications are unveiled for existing facts and theories. The progress of science has, however, also a corrective aspect. In other words, light cast upon certain theories from a certain aspect may prove their one-sidedness, calling for correction, or combination with other aspects may demand certain changes. Finally, certain concepts may become outdated by findings leading to others. This does not detract from the historical value of any idea which, from the historical angle, may prove to be the basic concept of an entire era of mankind, although it may be valueless for a later one.

Modern depth psychology has taught us three fundamental things about the inner life of man which will never be discarded even though some of the individual theories of this "new psychology" become outmoded, overdone, or overcome by new discoveries. These are the demands: 1) to see the human inner life as total, whole experience unit; 2) to realize the dynamic character of all inner human experience; 3) to see it in its great variability with regard to different kinds of human beings, as well as variety of age levels, social adjustment, and environmental changes. These three aspects mean more than any single theory. They are denominators by which the content of any individual theory or individual psychology can be confirmed, or its lack or weakness emphasized.

In applying the above to the concepts of Adler and Jung, we encounter difficulties in regard to certain major aspects of infantile and juvenile development. Adler, for instance, strongly emphasized the general inferiority situation of each child in regard to its adult environment. But he has brought forward very little concerning the relationship of his contradictory principles (inferiority and superiority) to the more detailed factors of the specific ego development which has become more and more a central feature of educational psychology. Jung, on the other hand, never presented this contradictory principle in the development of the structure of the growing psyche which should have been an amazing concept in his own structural view. Probably he felt that the task would have been almost as great a one as developing the adult aspect, in his book: *Psychological Types*. However,

still another problem is involved. If we attempt, from our present knowledge of the human ego, to think to the end the concepts of Adler and Jung, we feel that they do not completely cover the theoretic needs of an understanding of similar problems, for instance the psyche of a kindergarten-age child. Neither concept seems to respond satisfactorily to the developmental aspects of the growing ego in a child. We can reflect from the adult angle and its application of both concepts to the attitudes of a baby before the development of its ego consciousness or of a child in any later stage of juvenile development, but the innermost dynamic pattern of the ego development cannot be explained by either concept.

Reflections of this kind and meditations and experiments over a long period of time have led me to develop a new concept which seems to me—as I have conceived it—to provide a more satisfactory instrument for the understanding of the ego development and its deviations in early childhood. I, too, found myself inclined to develop a contradictory set of terms which I present here as *ego inflation* and *ego deflation*. The first of these two terms, at least, belongs to our common knowledge but it has been used in various ways and has been applied in a very specific way to psychological terminology. We shall discuss at length our suggestions for its use in regard to the ego. Our presentation will aim, on the one hand, to apply the common-sense meaning of the terms and, on the other, to guide our readers' thoughts to an understanding of the new concepts.

Let us start not with any general theoretical conception of a self or ego but with the most realistic and specific one. It is a great event in the growth and development of any baby when he ceases to call himself by his first name and begins to call himself "I." We call this moment "the birth of the ego" and know that this event is the beginning of self-consciousness. The nucleus of the mass of self-determined knowledge, of the formation of a personality, and finally of the dynamic expression of an individualized psyche is founded on this. And the entire further development following this event, which generally occurs about the third year of life, works through the entire period of the second

and third decade in a quantitative and qualitative sense on the growth of human consciousness based upon this original "I."

Everyone who deals with the normal and abnormal psychology of earliest childhood knows that deviations even of this most elementary ego experience can take place. They have been frequently observed and have even been made a symptomatic element for psychopathology. We know of many cases where a child changes much later from the self-designation to which his environment has accustomed him to the self-determined "I." We know that low-grade mental defectives hardly ever make this change and that we can diagnose special mental deviations in their earliest appearance in the cases where this change is accompanied by mistakes and permanent confusion. On the other hand, there is the type where the "I" expression shoots up like a geyser and the attitude of the child becomes a permanent "I," "I," "I." While the first-mentioned children seem to be too weak in the powers expressed in the ego to distinguish themselves from their environment, the last mentioned seem to be unduly strong in their demand for ego expression. Without doubt a contradictory attitude pattern is expressed in these two types of deviations. Those who observe more closely the various kinds of ego deviations in babies will discover that they cannot help subordinating either one or the other of the two types. Returning now to our own thesis, we must see that these two types represent nuclear forms of a deflationary and inflationary pattern of ego deviation.

We take these terms in their common meaning. Inflation, as exemplified for instance in financial inflation, means a rise in the nominal value without the backing of any actual value. The baby for whom everything becomes "I" actually inflates his ego experience, while the child who does not attain the ability of an "I" experience represents a nuclear form of deflation, which means a shrinkage of real self-experience, an inability to come to sound and concrete expression.

Of course these nuclear earliest forms do not represent a clear and fully developed picture. We have used them only because they seem to provide the most realistic approach to the understanding of our concept.

Let us now proceed with an attempt to find a still better understanding of these inflationary and deflationary tendencies by a study of the dynamics which seem to be the major element in their cause. Whatever rôle is given the factor of the "I" in a child, we know that not only is this an important factor but that it does not arise spontaneously but has a very definite determination. The behaviorists have given less thought to the genetic question here concerned than have the followers of Freud (48) although his biogenetically conditioned concepts of id-ego-superego do not show much insight in our subject. Following the abstract method of Freud, we could apply our own concept and say that ego inflation is caused by a breakdown of the border between ego and superego and by the ego's taking on a phantom appearance of the superego. On the other hand, we could call ego deflation a weakening of the ego by the subconscious powers of the "id" (52), either by way of developmental weakness of the ego and great strength of the "id" or by a pathogenic process by which the original strength of the ego is "deflated" by the powers of the "id." We do not consider that this Freudian concept has a deep enough insight into the differential aspects of ego inflation and ego deflation, especially in the various stages of youth development and their concrete problems.

It seems to the author that the psychology of C. G. Jung (109, 110, 111) approaches much more closely a basic understanding of the primary aspects of our concept. Freud's abstract pencil sketch of the "id" is developed by Jung in great detail through his concepts of the subconscious archetypes, especially the mother-and-father archetype, which are the most essential mental powers underlying the development of the ego in a child. Of course it is ridiculous to suppose that the father-and-mother archetype can create the human ego or "I" in a child. Any child born with a normal heritage should be expected to develop an ego without assistance. The problem must be approached from a different angle. The ego in a human mind is like a seed which, without parental archetypes, would have to grow on a rock without nourishing soil. Father and mother archetypes are the seed-bed for the human ego. I have, in a sketchy way, attempted to describe the rôle of the *paternus* and the *materna* in a human

psyche as regards the father-and-mother influence. They are part of the psyche but they are not the ego even though they are deeply interrelated and may influence it. We must make it clear that the ego is a nucleus which is innate in every human being without any outside influence. The ego makes its appearance as soon as a normal baby has reached a certain physical and mental stage of development making it possible for the ego to take on the governing part in the total of a human being's experience. It can be suppressed or it can be urged forward unhealthily. These are two basic tendencies which create deviations of mental character. Of all the forces which foster normal development or which are psychologically indispensable to avoid abnormal development, the father and mother archetypes are the most important. But the father and mother and their mental existence are not the only influences which work upon the tender mind of a baby; the father and mother themselves are but parts of a wider collectivism such as that of the civic community and that of religion, nation, and race. Even nature, in the form of climate and locality may take a part. Finally, other individuals, such as siblings, relatives, servants, even animals, may have considerable influence. Any child's ego from the day of his physical birth to the date of the "birth of the ego," and from then on through the entire span of life, is socially influenced and shaped by these environmental factors. We must keep them all in mind in estimating the normal as well as abnormal development of any human ego.

Before the "birth of the ego" (117) the entire constellation of our aspect is different as concerns the normal as well as the abnormal. This mentally prenatal state of the ego during the first two or three years of an infant's physical existence can only be called living in a subconscious and collective mental state, occupied by an adjustment to the primitive pattern of living as dictated by the environment. Those who are interested in the early learning of the child have always been amazed at how quickly it assimilates all these environmental factors which it has taken mankind thousands of years to develop by slow and laborious learning. This early learning is not yet the work of the real ego, which could not actually assimilate all these facts so quickly.

This rapid learning is, however, an intercourse between the collective consciousness and the prenatal ego, a process which may be called subconscious remembrance. It is amazing how children, in the earlier years, have a tendency to reproduce social experiences of family and entire community life of which they cannot have a real ego experience. Most of the doll play of children would be misunderstood—if seriously studied—if it were not determined by the tendency of this subconscious drive to express the "remembered collective pattern." We point out these dynamics of the earliest ego development in order to be able to understand the earliest tendencies to deviations.

This aspect is specially important for the understanding of ego deflation. Deflation, as a term by itself, is less understood than is inflation; nevertheless ego deflation is a much more frequent and a much more serious factor than inflation. Much of the retardedness in early childhood, insofar as it is a real psychological and not primarily a physically conditioned factor, is due to deflation. All that which in the Adlerian concept concerns the social-psychological inferiority situation of a child is actually the social situation for ego-deflation. But its real sphere is even wider. Many factors, not only in parental behavior but also in the wider social environmental conditions, tend to hold back the proper innate development of a small child's ego. Such factors may not be those of ill will or poor conditions; they are often even excessive love, protection, and educational measures which actually discourage the tender ego from growing to its natural strength. Even if it is the natural tendency of a parent to believe his child wonderful even in the cradle, inflation caused by a too strong and too early urging of a baby's ego development is not so frequent or so dangerous as are the innumerable tendencies to deflation. Such early inflation can hardly have any more serious consequences because we are dealing with a psychologically prenatal state. We might incite a premature development of the ego by inflationary dynamics, but no actual danger is involved, such as retarding the development of the ego by deflationary influences. We cannot sufficiently emphasize that deflation is the major danger in the earliest stage of ego development, before the ego has grown to maturity as the center

of beginning consciousness of the child. Inflation in this period is of only secondary importance.

This early rôle of deflation and inflation changes considerably during the further development of the juvenile psyche. We shall see that inflation increases in importance and deflation decreases up to the level of sex maturity. After adolescence is reached the two dangers are almost equally perilous for the young mind.

Adequate and reasonable concepts of the development and maturing of the juvenile have been very slowly developed and even more slowly accepted by present educational psychology. The desire for such adequate developmental concepts has been one of the most pressing scientific demands of the beginning of this century, but we have vacillated between impractical theories of purely abstract character and others which, because of too much detail, have hindered rather than helped to understand the growth of the child. What help to proper insight can we receive from detailed charts giving monthly indications for the so-called normal development of the baby? A knowledge of specific factors of normal growth is essential, but one of the most important has apparently been least emphasized. This is the gradual and differential development of maturity. For many years I have tried to show that it is ridiculous to see a child's growth as a compact development of his entire existence. I have tried to emphasize that the mental maturing of a child is a process of slow development of the various forces composing the human psyche. It is now quite generally agreed that we must speak of the "birth of the ego" when the child begins to use the concept of "I." At this same period he develops a definite rational and reasoning activity which proves that he has matured enough to use his thinking power. We all know and speak of the start of the "questioning" age, which is a sign that the child has begun to use this thinking capacity. But during early life a child shows all the symptoms of an emotional immaturity which not until the seventh or eighth year of life reaches a stage of development which can be called a ripening of his emotional personality. There is also the third stage of maturity, which is connected with physical puberty and which, in the juvenile psyche, is represented as the maturing of the will. I repeat these facts

only because they serve as a scaffold for my presentation of the problems of ego development. On various occasions I have discussed in detail the various aspects of this threefold maturity.

As we have seen, "ego birth" occurs at the time when the thinking and reasoning capacities of the child arrive at maturity. The two factors are closely connected. With the start of the basic and powerful urge to think and to know, the tendency to "overdo" is quite obvious. Since this tendency is an indication of inflation, we must henceforth watch carefully for all the various tendencies to inflation in the sphere of the child's thinking. We should not, however, be over-anxious and mistake any phantasy outlet as a form of inflationary thinking. In the age group up to eight there is much of the earliest pattern of pre-ego phantasies already described. When the kindergarten and primary school child does not find the definite experience for collectively inherited knowledge of social and knowledge patterns, his phantasy steps in and often creates quite scientifically expressed fairy tales and adventure patterns characteristic of early school age.

However, there is a clear line between healthy juvenile phantasy development and the type of maladjusted morbidity of intelligence utterances in this age period which is caused by ego inflation. Let us consider a characteristic case. It is that of a boy of seven, whose father is an editor of a popular magazine and whose mother is a chronically sick, highly neurotic woman unable to care properly for home and material duties. The father is a boastful, professionally insecure and, owing to his unfortunate married life, unsatisfied person. His only hope is concentrated on his son in whom he imagines unusual abilities which he desires to encourage for his own satisfaction by pushing the boy's development. The youngster is physically very weak and is actually chronically ill with children's diseases, colds, and a nervous stomach ailment. He is rather annoyed and tired by his father's constant attempts to show his superior learning abilities but, on the other hand, he is thrilled by the attention and gifts he receives. In school he is far behind. His teacher reports: "He knows lots of things but cannot answer any question correctly. He hardly writes as well as a child in the second grade." At home he reads anything he can lay hands on, especially news-

papers and big dictionaries. When guests are in the house he puts himself with a big Webster in the middle of the scene. Before anyone can answer a question he intervenes, generally with anything that comes into his head. *Ego* tries to talk to anyone who comes his way, especially policemen, and he tells all sorts of fantastic tales. When questioned about anything he has mentioned or a fact about which he has read, he proves to have only a slight knowledge and a very poor perception or imagination. Along creative lines he always attempts short cuts. He likes to bring paradoxical things together, making jokes out of verbal distortions and incorrectly matching words which have a double meaning. All his intellectual life seems to be on the surface of his mental existence in which his ego plays a weak, almost non-existent, rôle. Accordingly he is terribly weak in decisions aside from will patterns dictated by his own primitive desires or affects in which the ego is not the governing element. He is a typical example of an ego inflation of the primary age group before the age of seven.

Let us now describe an almost equally characteristic example of ego deflation of the same age group. It is that of an undersized girl, physically impaired by a premature birth injury and chronically ill with deficiency diseases and colds. Because of this condition she has been too much overprotected and held back by all the members of her family. She has always been "babied" and she enjoys it. Although, considering her physical condition, she has an excellent school record, she is mentally as inactive as possible. She does not like to read but prefers to look at pictures and comics. She does not care for any new information. She seems almost unable when she repeats something told to her to "get it in her mind." But what she knows, she knows and remembers very exactly. When she is taken somewhere or given a new experience, she repeats: "Have I not seen (or heard) this before?" In her social activities she tries to comply with any rules as minutely as possible. She not only obeys perfectly but almost always waits to be told what to do. If she is urged to any greater activity, mental or physical, she quickly becomes exhausted and falls asleep. She likes neither to be in a large group of people or alone, preferring to be with some one

of her relatives and to carry on a very slow and unoriginal conversation about the most primitive things, such as the past or the coming meal, what everyone in the house has been doing or expects to do. She is a little group-being, without much personality or aggressiveness, but she is of normal intelligence.

These two cases represent the extreme types in the contradiction of ego deviation of the primary age group. Let us sum up these contradictory patterns. The child with an inflationary ego development in the intellectual maturity period shows symptoms of great activity, apparently wants to know everything but his desire is only superficial as his assimilation of any knowledge. His real knowledge is a medley of half-truths and misinformation. He has little exact information and is unable to combine correctly any facts. What he produces is fantastic and only done to "show off" or to satisfy an immature hunger to be acknowledged the center of his environment. The deflationary type shows the reverse trends. It has great difficulty in assimilating new knowledge and in widening the horizon of its inner life. But what it does assimilate is carefully kept and well preserved. There is a permanent reluctance to step out of a small secure environment and the conventional collective pattern in which it knows it can move and express itself safely.

Among the secondary symptoms produced by the deflationary type are the language difficulties. Many psychological stammerers and stutterers are such deflated egos. The same applies to reading and other special learning deficiencies. Our attempts at remedial learning could gain much from considering the general ego-deflation pattern as the background of such symptoms and they will be more successful if they attempt to overcome this ego deflation than if they try to make a generally weak child struggle against a special disability which is only a superficial expression of the total deep-seated illness. Naturally many mentally retarded and slightly defective children—especially of the encephalitic type—show the behavior pattern of ego deflation.

Before describing the ego deviations of the second age group I should like to discuss the general aspect. We are attempting here to give a differential presentation of the ego deviations as they occur in the various age levels of childhood as determined

by the gradual maturing of the young mind. Ego deviations may appear in any of these age levels independently because the child's intelligence, his emotional and his will and affect nature are unable to mature properly. On the other hand, the ego deviation maybe a general one, continuing from the beginning and appearing in different forms, earlier ones combining with those of the next period. For instance, children who develop an ego deviation in the first period, that of maturing intelligence, will also show similar symptoms in their total behavior. These other symptoms, however, are secondary and can be overcome when the second period, that of emotional maturity starts. Often a sound development in the second period is the best remedy for an ego deviation during the first period. However, if the ego deviation is so pronounced that it recurs in the second or even the third period, it indicates a very severe form of mental illness. The majority of such children fall into the category of patients whose only hope for recovery lies in institutional treatment. If not clearly evident in the first period of development, the ego-inflated type will develop later into a pattern corresponding to our too broad designation of schizophrenia. Insofar as they apply to this presentation I wish to use the statements in my previous chapter on "Childhood Schizophrenia and Childhood Hysteria." All these children prove more and more to lack a directive center and nucleus for their psychic and mental life, a lack which is characteristic of the type of childhood schizophrenia which I have emphasized. If the inner "breakdown" does not occur in the period of emotional maturity it will almost inevitably appear with the first signs of puberty. Very early therapy may prevent the worst manifestations.

What has been emphasized for the ego-inflation type applies equally to that of ego deflation which has this deviation all through childhood. However, our comparison of childhood schizophrenia—according to our concept—with childhood hysteria does not apply to ego inflation and ego deflation. In other words, children with ego deflation are not of the hysteric type but rather the higher type of mental defectives with generally retarded development. Some may have slight hysteric symptoms but they hardly reach the pattern of definite violent inner re-

sistance leading to hysteric episodes. They may assume the hysterical dynamic pattern when they wish to resist being pushed in any direction but they have not the energy to come to any definite expression and are more apt to develop into the hopeless stupor form. General ego deflation is almost always combined with some physical ailment, neurological or otherwise and for this reason ego deflation need not be considered an independent somatic picture such as ego inflation.

When boys and girls about the age of seven or eight reach the point where their emotional dynamics approach a new "stage of birth" in reaching emotional maturity to become the basis of their personality structure, many show symptoms of ego deviations in one direction or the other. One type wishes to embarrass the whole world and, being unable to accomplish this purpose, flies into a passion. The other type is the introverted, closed in and filled with a deep inner melancholy because lacking the means of expression. The first are the inflated, the second the deflated ones. In all emotional growth there is a great tendency to inflation, therefore it need only be considered from a psychotherapeutic instead of an educational standpoint if the severe abnormal forms remain active over a longer period.

In the case of a little girl of nine, her family setting was obviously responsible for her emotional ego inflation. Her mother had been divorced three times before she married an older traveling man to whom, as she tells everyone, she accidentally bore this child. There is no doubt that the child was rejected and in the way of a mother with very little maternal feeling. Shortly after her birth she was placed in a religious institution. When she developed an unusual doll-like beauty the mother decided to take her home, certainly without any idea of benefit to the child, but to please herself. At the institution the girl had developed to a fairly normal level. She was of average intelligence and easily guided. Coming home meant for her, on the one hand, the loss of the institutional frame which may have permitted less inflationary development of her ego and, on the other hand, exposure to the superficial, pleasure-loving, and completely uneducational sphere of the mother. At first she thought it was wonderful and like dreamland. She had all the pleasures of life:

movies, restaurants, nice clothes, admiration. The natural inclination to such things, which was in the depth of her nature, began to come to the surface but she was unable to find the right ego balance and had, of course, not the proper guidance. She began to make friends with everyone, showing off and wanting to be admired. When placed in a public school she attempted to have every girl as a friend, coming home with a different one every day. Soon she was the most hated child in the class. She was found in lies and was even accused of stealing. She was equally disliked by the school staff because she was always trying to call the teachers' attention to herself. After she had made school impossible for herself and her mother still persisted in an extravagant, show-off life for her, she broke down into a neurotic hysterical pattern in which she was brought to my attention. She burst out crying on all occasions, started to bite her finger nails and to get confused during the day and restless at night. She rejected any permanent relationship but was always on the lookout for a new one. When she had to wait in my waiting-room during a few minutes' discussion with the mother, she made contact with another patient and was in the middle of a "story" when the mother picked her up. She was always eager for new emotional experiences without any foundation on a sound ego pattern. She was a typical case of ego inflation in the emotional stage.

Just the opposite of this case is the story of a boy of nine, the son of an accountant and of a very restrained but kindhearted mother. Both parents were desperately overexact and correct, attempting by restraint to adjust themselves to their conventional life. The child was offered nothing to build up his pattern of juvenile freedom. Although a child, he was expected to live an adult life. His behavior was excellent "according to conventional pattern." He had been best in kindergarten and at the head of his class during the first three years of school. Suddenly he began to slacken and his marks at school to fall off. This was the only fact that brought to his parents' attention that he was getting into a seriously abnormal mental state. The slackening was not due to intellectual weakening but to a weakening of his inner powers of control by an emotional ego deflation at the be-

ginning of his emotional maturity. The trouble began when he started to compare himself with his schoolmates. They had always called him a "mother's boy," but this did not mean much to him until he really awoke emotionally. Now, when the waves of adventuresomeness, enthusiasm, and admiration, as well the boys' emotional plan-making, swept through the group, he felt that he was missing something. He began to feel insecure because he could not do as they did although he felt that theirs was the right way. When he tried to join in, he felt his failure and his inner weakness so strongly that he almost fainted. Formerly he had not done so badly in athletics, but he became so afraid of being laughed at that he now failed. More and more he wished to be left alone to enjoy being miserable. When he was brought to me he was in such a state of melancholia that it took me half a year to bring him back to his former intellectual level and much longer, with a great deal of parent education as well, to balance his ego deflation.

Many children with emotional ego deflation show various psychosomatic symptoms. These symptoms are conditioned by an organic weakness with a constitutional background. Frequently such organic illnesses are not seen in their proper light, and the impossibility of curing them with laxatives, vitamin pills, and glandular substances should make the pediatrician more aware that the body of the child of later public-school age in the state of emotional maturing is highly vulnerable to its first emotional adventures. It is only rarely that ego inflation short-circuits the body, but many ego-deflated children are brought to the physician for physical treatment only, instead of to the psychotherapist.

Although it is sometimes not too easy to discover the border line between actual sickness and some natural emotional outbursts in the emotionally ego-inflated child, it is more difficult to find the right way with the ego-deflated one. Nothing is so open in school children as the expression of emotion, and a pathological pattern in a case of ego inflation should be obvious to any fairly observant parent. Ego-deflated children may suffer for a long time from depression and internal conflict before this comes out into the open. A sudden falling off in the quality

of schoolwork of a child who formerly was normal intellectually, when he enters the emotional period, should always be carefully investigated and not set aside with scolding or superficial educational treatment. Many youngsters have been broken for life during this period. It is only recently that we have again begun to take emotions seriously. The word was banned by the behaviorists just as "feeling" was from the psychological literature. However, if we now make too much ado about emotional factors, that is not the point. We cannot investigate too carefully any trouble of an emotional character, especially in a child with a tendency to ego deflation, since his entire later healthy development depends on this. Finally, ego deflation must be considered a very serious condition when it occurs in a fully developed form in a child of this age group. Fortunately, it is rather rare. On the other hand, ego inflation is a rather frequent ego deviation at this age level, but it can be easily corrected and quickly overcome unless it takes on an exaggerated form.

Turning to the third or last maturity stage, that which coincides with puberty as the final ripening of the will powers, we repeat our former statement that in this period ego inflation and ego deflation seem to hold the balance as regards their frequency and their role in the mental life of this age group.

To make our concept more fully understood, it seems necessary to discuss the relationship between sex-maturing and final maturing of the individual child's will powers. If there is one point on which Freud's sex psychology and his libido theory have a justification it is this one. All my observations in this direction through decades of work with children have convinced me that there is a definite connection between our final will-power decisions and our will to live and to continue through propagation. This does not mean that like Freud I would determine all human striving by the unconscious libido and sex background. I believe that our intellectual and emotional forces are independent of the libido basis of human vitality and I do not wholly believe that sex is so unconsciously connected with them. However, in the final decision to live, will power and sex are connected in an indefinite but deeply rooted way. Therefore the final maturity of the will is connected with the final matur-

ing of the ability to propagate. On this point I must once more emphasize my difference from all concepts of juvenile sexuality. I do not believe we should speak of sexuality in a human being who is not yet physically mature. There is no actual infantile or preadolescent sexuality for all human beings as maintained by the Freudian school.

However, one aspect of Freud's theories seems to me important in the consideration of ego deviations. This aspect is formulated in his theory of the life and death drive. It would be easy to identify in a superficial manner superego and "id" deviations with ego inflation and ego deflation, and in the same way we could find aspects of relationship between deviations of the life and death drive and our concept. We point this out because it may help us in some degree to understand the attitudes expressed by sufferers from these deviations.

Although the ego deviations of adolescents express almost everything that concerns psychic life, the center and source of the deviations must be seen by the manner in which decisions and will expressions are formed and executed. Social and professional ambitions, and especially the early sex attitudes, are major forms in which these deviations find their expression.

Among my many cases of ego deviations in adolescence, one is of great significance and unusual pattern. Two children in the same family setting represent characteristic symptoms of the two types of deviation. They are the sons of a small-town doctor who himself seems to have been highly efficient and busy with his practice. The two boys, one eighteen months older than the other, seem to have been well brought up and without unusual psychological characteristics until the sudden death of the mother when the older boy was ten and a half years old. The father at first seemed to be terribly upset but after managing his "mutilated family" by himself for a little over a year and after definitely deciding not to marry again, he took a younger woman into the house "to care for himself and his needs." The boys, who apparently had been completely neglected during the interim period, were now sent to a large private institution in a city some distance away. There had always been a sibling problem, since the elder was a rather outgoing, sociable boy

while the younger, who was extremely nearsighted, had always needed the special support of the mother to overcome a shy and inverted disposition. As long as the mother was alive there had been no actual problem as far as his school work and his social behavior were concerned. The older boy had always sought companionship with the father while the younger was much with the mother. After her death the struggle between the boys was accentuated since the father attempted to make the older boy "his brother's keeper." He was equally mistaken in his idea that boys of their age could take care of themselves, an idea with which he justified his desire to send them away. Left to themselves in the larger town, and with the onset of puberty shortly after they were deprived of their former parental guidance and protection, both boys rather quickly deviated from the healthy pattern. The elder boy became a typical case of ego inflation. His relationship to his father had always been very superficial since the doctor had actually never had time to concern himself seriously with the inner development of his son. The life of the big city soon swept him off his feet. He found school less interesting than soda fountains and street-corner companions. Since he was large for his age he got into the company of older boys. Dress, showing off, and girls occupied him. Aside from this, his professional interests ran to cars, sports, and show business. During a period of several months, when I saw him regularly, he had a different plan for his future life at every visit and seldom the same one twice. Soon a pattern of insecurity and discouragement emerged. He got nowhere in school or with the boys, and especially not with the girls. Only fear prevented him from stealing in order to make the impression which his personality did not achieve. He tried new things repeatedly, accomplished nothing, and depression periods alternated with new attempts. He had periods of flaming hate without being able to achieve the planned revenge. Since his premature sex desires found no way of satisfaction he fell into an exhausting pattern of masturbation, the symptom of which was the imagination of the desired object. When I discussed the case with the father he called the boy "morbid" and, although I did not agree with his views, this designation seemed justified.

Meanwhile the younger brother had developed an ego deviation in the opposite direction. He had become a characteristic case of ego deflation. Always inclined to be introverted and strongly restrained he had, by his mother's help, gone unharmed through the emotional period. When he lost his mother he was unable to adjust himself to the changed conditions. It is to be noted that this younger, deflation-conditioned boy reached puberty much earlier than his inflationary brother, both boys maturing at almost the same time. He seems to have suffered tremendously at puberty and masturbation was his only outlet. The deflated boy had a different pattern; he did not use his own imagination but pictures he picked up here and there. His first symptom was retardation in school. He showed almost complete listlessness: while his brother was "always chasing all over" as he put it, the younger did not want to do anything. He did not arrive at any impulse by himself. What he liked best was to sit and daydream, or to sit and listen outside an active group. His father called him lazy, but the specific trait was not actual unwillingness but inability to "get himself together." He had no energy for anything: it was hard work to get up in the morning, hard work to eat, or to sit around in school. He always had to be pushed. When asked about his plans for the future he would answer slowly that "some time he would start something with a friend." Indeed there were always a few boys, mostly older ones, who liked the company of this silent bystander and he always made good in such relationships. He found in them a remarkable security in his limited sphere. He even showed an astonishing degree of endurance. He was willing to accept guidance, while it was almost impossible to approach his brother.

In both boys the actual pathological element was the will factor in connection with their maturing age. They represent the two contradictory types of ego deviation, in the adolescent forms. In both boys the factor concerned was decision and action. While the inflated boy was full of unadjusted wants and aims and desires he always failed in the execution of his aims. The younger, in his deflation pattern, seldom even started: he was unable to come to a decision or to undertake anything. He

was limited in his ideas and entirely dependent on others. The elder had few social relationships and wanted to do everything alone; in fact he was almost always forced to do so since nobody, in the long run, wanted to have anything to do with him. These are the specific traits of the ego-deviation forms in the adolescent stage.

We have already emphasized the difference in the pattern of sex deviation. One of the most important contributions of our concept to practical education seems to be along these lines. No one can deny that so far we have pitifully little information on differential behavior patterns concerning masturbation in adolescents. This is very important if we wish to give concrete help. The ego-deviation concept seems to give real insight into the deeper lying mechanism of this severe adolescence difficulty. It is a means of overcoming external and superficial evaluation of symptoms and of getting at the source of two major patterns. Not only in this individual case, but in a number of others, I have observed the identical pattern. Boys with ego-inflationary dispositions use their own imagination as stimulation, while those belonging to the ego-deflation type produce stimulation by outside imaginary means. This gives us a concrete factor for therapy of these common masturbatory attitudes which most of us were helpless to influence directly. By easing the inflation or deflation burden of youth we can find a concrete approach to the overcoming of this type of masturbation. Of course we shall be successful only if at the same time we try to influence the mechanism of imagination as it has been taxed by this abnormal attitude.

These adolescence ego deviations differ considerably in the two sexes. Even though today the social expressions of the life attitudes of boys and girls have been considerably equalized in some respects, such as professions, sports, and clothing, there are basically different patterns simply owing to the fact that we are dealing with growing men and women. However, I have attempted to find a common denominator appropriate to both sexes. If we watch for ego-inflationary expression in the tendency toward aims and ends of action, and if we recognize ego

deflation in the inability to reach decisions and to initiate actions, we shall be right in diagnosing one or the other, regardless of sex.

As regards the therapeutic aspects of our concept, the value of the differential consideration of the ego deviations lies in the possibility it provides of finding more concrete means for therapy than were possible from a more general angle. In our theory of ego deviations in youth we have brought together two major aspects: (1) the contradictory pattern of ego deviation, and 2) the concept of threefold maturation. In any concrete attempt at therapy we must unite these two aspects. This means that we cannot apply in the emotional or puberty period some remedies which have proven helpful in the period of intellectual maturity.

The strengthening of the ego must be the basic task no matter what aspect of the deviations is considered. However, even in the principal differentiation of inflation and deflation the task is not the same: elimination of an ego inflation is not the same as elimination of an ego deflation. In inflation the child must be made aware of the real substantiality and security of the actual ego experience. He finds the needed security if he applies the real ego relationship or at least strives to do so. In deflation there is a vitalization of the ego which has never attained its real strength. The child's ego and its dynamics must be strengthened and he must be made to realize that through this he can gain the real capacity of independent and secure living. The aim of both remedial processes is to give the child the final affirmation of his ego experience and the feeling of definite security if he lives normally through his ego.

On the other level, that of the maturity stages, we must in the first place realize that the role of the ego is one which increases progressively in strength. The problems become more complicated as maturation advances. The easiest problem is that of the primary group where it is primarily intellectual. However, we must not believe theoretically that simply a correction of thoughts will help. We must realize that even at that stage the entire child is involved. Our remedial task centers in the rational development of the child. As in any therapeutic attempt, a per-

fect adjustment to the level of the child's ability is the basic condition of real help. We must be able to think as a healthy child of the primary age level thinks if we would help a deviated child to think correctly. It is useless to attempt adult methods of the school-teacher type with such a child. It is often better to return to the kindergarten type of pictorial instruction and even symbolic form pattern in order to give him a feeling of security in his need to learn to absorb facts and knowledge from the outside. It is ridiculous to force knowledge into the head of a child who has not yet fully developed the organs to absorb it. We must realize that inability to learn is an inability of the learning mechanism. This learning mechanism is the intellectual part of the ego which has not yet matured or has matured in the wrong way. The only reasonable remedy, from the ego-deviation viewpoint, is to go back and attempt at first a method of communication in which the child has already found security and confidence and on this to build carefully the new learning instrument.

A completely different attitude is necessary in therapeutic work during the emotional stage. Here ego inflation and ego deflation are interwoven with the emotional life of the child. Remedial work must aim to influence the basic dynamics of emotional attitudes. We are dealing here, not with facts, but with positive or negative feelings, and with the objects toward which these feelings are directed. All emotional ties go through some form of admiration and leadership, "crushes" and hero worship: the personal element is always involved. Therefore therapy implies personal involvement. At this stage we cannot teach; we must actually persuade such children to guide their emotional mechanism for themselves. Without very personal ties—some-what resembling the Freudian transference—nothing can be accomplished. We must always keep in mind the entire existence of the child. An emotional upset influences his ability to learn and to act normally. When the behaviorists' ban on feelings and emotions as nonexistent realities was lifted and realism forced our educators to accept them as vital elements in psychic life, a wave of emotionalism ensued which in its turn overstepped the bounds of reason. Too much is now spoken and writ-

ten of the part played by the emotions in juvenile life without a clear knowledge of their rôle in the total of the human psyche and their relationship to the other forces active in our inner life. The immense importance of this knowledge to an understanding of the emotional maturing period of our children is obvious. Only a correct understanding of the place of emotions in juvenile life and development can enable us to do the right thing. In evaluating properly the rôle of the emotions we shall soon realize that we have overemphasized the importance of the emotions in adult as well as juvenile inner life, but we insist that everything that can be done to help children overcome ego deviations during the emotional maturation period must center in or circle round corrective measures directed toward the emotional mechanism. We must realize that juvenile emotions are not adult emotions and that dogmatic "transference" and rationalization which may be utilized in cases of emotional disturbances in adults are *not* the right psychological medicine for children. During this period the intellectual forces must be guided through the emotional ties, that is by the influences of will and action. Those who have learned to distinguish clearly these differential patterns of ego deviation know that it is much more difficult to guide a deviated child during the emotional period by means of reason than it was a child of the primary school type.

Quite a different basic attitude is necessary in dealing with the adolescent. This age group cannot be guided and directed through emotional leadership. The specific trait of the adolescent ego is that it wants to decide and do everything by itself. We must apply our remedies for ego deviations through the technique of encouraging the adolescent to do the right thing in the right way. Work with this age group is the most difficult task of psychotherapy as applied to youth. Emotional, as well as rational experience, is of secondary importance. The most difficult achievement will always be the education of the parent, who must be taught to acknowledge the natural demand of the teenager for self-decision. In dealing with a child who has a serious ego deviation, it is almost more important to start the therapy with the parents or guardians than with the child himself. Few will agree that this aspect also in many cases includes the

teacher or employer. As concerns the youth himself, the less we dogmatically reason with him the more success we can expect. Reasons contributed by other people seldom mean a thing to him; he has to be helped to work things out for himself in his own mind.

This is especially true of the sex problems which often threaten to overwhelm these youngsters. Scolding helps as little as does the theoretical method of instruction. Youth has a much stronger "tabu" feeling than adults, especially in a deviated state. I have often been gratified by my success in treating severe sex disturbances without even mentioning the rough words of our language and carrying on my conversation in a symbolic manner. We spoke about difficulties, weaknesses, and how to overcome them, and we understood each other perfectly. The harmful influence was overcome and a feeling of security against fear and shame was established. I never suggested authority but left my young patients perfectly free to select their own way of helping themselves by the aid of my suggestions which were given objectively. During later sessions I often heard: "What you told me did not work the way I applied it," or "I think I selected the wrong one of the two suggestions you gave me; please tell me the other one again." This is the only way in which adolescents really profit from our help and obtain the real confidence they need to overcome their troubles. Unfortunately, it will probably be a long time before public opinion ceases to condemn sex deviations as crime or immorality. Until we learn to see that these deviations indicate lack of strength of a healthy ego to cope with the powers of nature in the growing body, we shall not have the correct understanding of these severe sufferings of our youth nor a sound basis for helping them.

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DEPRESSIVE AND MANIC DISEASE IN CHILDHOOD

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MY PERSONAL INTEREST in this problem has been aroused both by the neglect of traditional discussion of depressive and manic illnesses, and by personal observation in my own work of a number of cases which not only do not fit into any other conventional classification, but call more insistently than ever for a differentiation and enlargement of previous concepts of manic-depressive diseases. Leo Kanner, in the first edition (1935) of his almost encyclopedic text on *Child Psychiatry* (121), has a limited discussion of depressive and manic diseases on a general level, with some beams of light thrown on the juvenile forms. But in the 1950 edition of Kanner's *Child Psychiatry*, this entire section was eliminated, and no mention of either depressive or manic expression can be found. John D. Campbell, a nationally known psychiatric worker, submitted a paper on the treatment of mild cases of depression in private practice to the committee of the American Psychiatric Association's 1951 Convention. This paper was rejected as having no scientific merit. On the other hand, increasing numbers of workers can be found who are convinced that even among juveniles there exists a syndrome that can justifiably be called manic-depressive, and who are anxious to have a proper scientific discussion of the problems involved.

In demanding a re-entry of the concept of manic-depressive diseases into discussions of current abnormal psychology and

psychiatry one must review the development of the entire concept. Until recently, most textbooks correctly stated that it was the great formulator of most psychiatric concepts, Emil Kraepelin, who also formulated that of manic-depressive disease. In building the basis for a scientific psychiatry he had to replace the old concept of melancholia, to which too much moral and religious sentiment was attached, with a concept which covered the dual pattern of emotional deviation in which he saw the manic-depressive illness expressed. Kraepelin's ingenious mind not only visualized this disease as one of the entire emotional sphere, but of the total personality. He also envisioned that this ailment had, in most cases, a genetic source in early childhood, a fact hardly anyone later has seen as clearly as he did. I would like to quote here a sentence from Kraepelin's *Einfuehrung in die Psychiatrische Klinik*, giving in his classical way a description of the best short presentation of the entire syndrome ever attempted: "*Der Beginn im jugendlichen Alter mit einer traurigen Verstimmung, den spaeteren Wechsel zwischen Manie und Depression, das Vorkommen einzelner schwerer neben zahlreichen leichten Anfaellen, die dem Laien kaum als krankhaft erscheinen, finden wir in derselben Weise ungezaehlte Male wieder.*" Kraepelin's—the discoverer's and problematist's—beginnings were improved and broadened in importance by Eugen Bleuler (25), the systematist, who clearly discriminated the manic-depressive somatic picture from that of dementia praecox, and gave it both frame and place in the total psychiatric system, in a way that has been held up as a model wherever reactionary influences from America have not penetrated. Even the "classic" American text, that of Jelliffe and White, still uses Bleuler's basic concept. However, to find the most efficient and clearest presentation, one must go to the English textbook of psychiatry, by Henderson and Gillespie, which, in the fourth edition (1947) (97), has even assimilated the modification of the old classification advocated by the American Psychiatric Association.

The tragic regression of sound presentation of the manic-depressive syndrome is associated with the American psychiatric leader, Adolf Meyer. In spite of our respect for all he has done to promote psychiatry and mental hygiene in this country, we

must severely criticize his discarding of the concept of manic-depression and blurring of the early concepts of schizophrenia; his attitude is not justified by the scientific observations he presents as reason and proof. The internationally-minded, objective surveyor of the development of psychiatry can only point out that Adolf Meyer must be considered an offshoot of the Zuerich School, with its biopsychiatric attitude. He was always the "younger brother" of Eugen Bleuler, a relationship he has tried to make invisible by pushing aside as unessential or reinterpreting Bleuler's basic teachings. We have even been told that he violently opposed the English edition of Bleuler's textbook (25), which White and Jelliffe were anxious to offer to the American student and which finally was accomplished by A. A. Brill. Completely eliminating the concept of manic-depression from its important rôle in earlier classifications, and watering down the entire concept of depressions, Adolf Meyer did nothing to tidy up the rubble of a demolished house or to build a new one. We find nothing in his writings to cover or replace those somatic pictures which he denounced for being called depressive and manic. And his authority in the eyes of a large group of American psychiatrists has almost completely halted further discussion. As psychiatric classifier under Adolf Meyer's regime, Nolan D. C. Lewis has confused the entire issue to such a degree that even liberal and middle-of-the-road workers have the greatest difficulty in finding their way, terminologically.

On quite a different track, and one completely outside of the discussion of official psychiatric terminology and classification, a new beginning in work on depression problems was made, at the same time as Adolph Meyer's influence was increasing. This new start was concerned with children, and it emanated from the psychoanalytical educator, Melanie Klein (122, 124). Whatever one may have against her psychoanalytical radicalisms, the fact that she formulated, with extreme clarity, the problems of childhood depressions is one of the laurels no one will be able to take away from her. Following her lead, the always fairly independent child-analysts have gone a considerable way ahead in preparing a platform for our present discussion—the whole

problem of depressive and manic-abnormal utterances in children. Of course, we are not placing ourselves within the framework of the Freudian school when we point to these attempts to discuss manic-depressive symptoms, and to probe from its viewpoint into the problems of depressed children.

In making a neutral approach to the problems of depressions and mania in childhood, we must clarify several basic points. The first is the relationship to the often-described adult pattern of manic-depressive psychosis and to the various forms of severe depression which have been fairly clearly differentiated. As I mentioned above, the presentation in the Henderson-Gillespie textbook seems to me to offer the best comprehensive survey and the best detailed descriptions, and I shall use it here as a basis for discussion. From this, we accept a specific adult pattern of manic-depressive psychoses, as well as specific forms of depressions. In attempting to survey the entire problem the first question we have confronting us is that of the start of the adult form and the presence of any preliminary conditions in individuals known to us to have become subject to these diseases. Can we find certain abnormal conditions in the life of these ailing adults which can be considered premature forms or conditioning of the adult disease? As is well-known, no thorough investigation has yet been made giving insight into this problem.

The second point we have to consider is, are there existing actual juvenile forms of depressions, and of manic-depressive disease? In attempting to distinguish juvenile forms from adult, we return to our constant emphasizing of the necessity to develop a separate field of child psychiatry. The fundamental question is, how far can we use the symptoms we know as specific for the adult form to establish the existence of the juvenile form? And further, in what way is the juvenile form completely different in its symptoms from the adult, and what are the ways of identifying both which would justify our calling the juvenile form by the same name?

The last is actually conditioned by and contained in the two previous questions: Is there a common denominator of identical symptoms for the adult and the juvenile forms of any kind of depression which may be used as a basis for the complete re-

shuffling of the entire complex of leading syndromes, and to a reclassification of all abnormal depressive expressions as far as juveniles are concerned? I would like to point here to the similar experience we have had with schizophrenia, in a process of scientific transformation which has not yet come to an end.

This chapter is concerned with discussion pertaining to a general basis or denominator of all depressive symptoms, especially the genesis of those one is able to point to in early childhood.

There seems to be agreement upon the mildest form of depression—a certain abnormal emotional behavior which again and again has been designated as *moodiness*. There cannot be much doubt as to what we mean by this word, or that we all know of moody spells in many of our children, even down to the age of three. The only question is where we can draw a line between moodiness as a normal reaction and as an abnormal condition. From the pediatricians we know that children of pre-school age have much easier and stronger emotional reactions to physical discomfort than to adults, because of the lack of personal controls. Our article on allergy-reactions gives a vivid picture of just how much physical conditions can throw children of all ages out of emotional balance. The material used in my own study of juvenile hepatitis actually came first to my attention not because of its physical symptoms, but because of a specific kind of grouchiness and moodiness, combined with restlessness (*The Nervous Child*, vol. 7, no. 1). This frequent type of abnormal behavior was one of the first I struggled to clear from the stigma of designation as a special depressive type, until sheer coincidence led to the discovery that we dealt not at all with an actual depression, but with a pseudodepression, or if one prefers, *secondary depressive symptoms*. Here, as in many longer-lasting physical ailments, such depressions appear as their psychic effect. Of course, we could not call these types of depressive symptoms actual depressive neuroses or even psychoses. However, in singling these factors out, we point to the sphere of experiences in which certain depressive disturbances can be observed as abnormal periodical moody or somber behavior, or as periodical unconditioned excited behavior, or as any of those repeated performances on the abnormal level. And here I

may immediately point to the well-known type of infant which we are accustomed to call the "serious baby."

We all know this strange type of infant which is so different from the usual baby, who is always ready to experience, to observe, and to smile. The serious baby doesn't know how to smile, and seems to have very little interest in what is going on around him; the serious baby is primarily occupied with himself. He frowns a great deal, and in circumstances where the average child expresses curiosity at a strange, unexpected experience, the serious baby immediately bursts into tears. If one can speak of a real emotional life at this age level, this "seriousness" is certainly the expression of something more or less like a slight depression. If one watches such a "serious baby" over a long period, one may observe that his general mental state is less even than that of most children; there are more waves of different grades of experience going on in him. In particular, there are certain spells which usually start with a deep sigh or groaning, followed by some internally motivated activity. The first manifestation is usually a waving of the arms, later a kicking with the feet, or running about shaking the head, or dancing. For the most part, these spells last only a few minutes; sometimes they may last longer and the parent who is accustomed to see the child silent and not very active will complain that it "sometimes becomes a little silly." There is a deep contradiction between these two behavioral states, and I can only point to this total picture as a kind of *embryonic form of manic-depressive behavior*. Of course, it is quite different from what we know as the adult pattern, but in principle it is a similar contradictory emotional behavior, on an infantile level.

Proceeding a little in age, we find another popular evaluation of a particular childhood behavior pattern—that which parents and nurses speak of as a boy or girl's "bad day," which may occur down to the age of five or four. The child wakes up grouchy and is in a bad mood all day. We know that such periods can last much longer than twenty-four hours, and that all attempts to find a physiological or outer motivation for them fail. We can also detect that such periods have different grades of emotional disturbance as well as a different tonus from spe-

cific depressed and upset states. We have here again some kind of juvenile abnormal behavior which falls in the direction of what we later designate as manic-depressive periods. Those who have followed me so far may wish to mention here another somatic picture named and described by Benjamin (22), as the "*Trotzperiode*," or *rejection period*, which, as we have learned from Benjamin, occurs in almost every child's life at an earlier or later stage. During this period, the length of which varies considerably, children are most sensitive to any persuasive influence from the outside. They say "no" to practically everything that is suggested to them. I have tried to understand this "*Trotzperiode*" as a stage during which the inner ego development makes the child wish to work things out by himself. He is slow and negative towards many things, impressions as well as persuasions coming from without, because he is too occupied with inner development to bother with them, or because he is overwhelmed by the number of things happening to him or demanded of him. We cannot discuss the "*Trotzperiode*" here in more detail, but we must mention it because we find associated with it a considerable quantity of depressive experiences and expressions which have led sincere workers to believe that it is an actual depressive condition. In reality, we must classify the depressive expressions which occur during the "*Trotzperiode*" as being of secondary character, like those we mentioned in association with juvenile hepatitis. This however does not mean that we would do well to consider separate treatment of them. The treatment of the actual "*Trotzperiode*" ought chiefly to consist in leaving the child alone, or easing his relations with all outside influences; one ought to consider direct treatment of those secondary depressions or manic utterances if they take on a more serious character. It is not infrequent that such children fall into deep moodiness, especially crying spells or motility disturbances, running around aimlessly, breaking things and showing other manic symptoms.

The most difficult and crucial period of the juvenile manic-depressive picture for us to consider is the *preadolescent stage*. It is so, in the first place, because, as someone has correctly stated, in this period youth is considerably labile emotionally,

and one often has great difficulty in deciding what is normal and what is abnormal for the individual child. In this period of excitability a great deal of moodiness is rather normal. However, one would do well to listen to Kraepelin, who said that most of what is essential remains unobserved by the layman, and to become more concerned on the level Freud tackled in his *Psychopathology of Everyday Life* about the small things, the less prominent utterances—if they show themselves to be frequently repeated factors. When we are more satisfactorily advanced in clearing up the problems of the actual juvenile manic-depressive illness picture, we will have to recognize that much of what is today thrown into the allover category of primary behavior disorders will have to be reclassified as manic utterances. Here, we will undergo the same experience we had regarding the somatic picture of schizophrenia which, due to academic superficiality, was made a grab bag for almost any kind of juvenile mental illness, and had not only to be pared down, but redefined and separated from various unjustifiable pathological cohabitants.

For a clear and not too difficult view of what is probably the most specific manic-depressive pattern in the preadolescent stage, one may watch for an unusual and unnatural enlargement of emotional expression in either major direction, positive or negative, and for a strongly contradictory pattern of behavior. There is, for example, the ten-year-old boy, who for a couple of weeks cannot be gotten up in the morning, although he goes to bed early, and who alternates this with a period when he will sit up till all hours without actually doing anything. We find similar behavior contradictions in regard to eating, sports, and social-relationship habits. I know of two cases of little girls who, after a period of great disinterest in their clothing, suddenly started a dressing-up spell, supposedly as a result of a crush on a young man. When investigated, the "prince" story proved to be a pure fantasy. *In all these pictures, the going from one extreme to another seems to me to point to an emotional disorder showing a juvenile pattern of manic-depressive attitudes.*

Toward adolescence and the middle teens, we find most frequently that familiar melancholic type, very often without a

manic extreme emerging as clearly as in most of the varieties of depressive utterance. On the whole, however, where we find specific somatic pictures of a manic-depressive character, they quite closely approach what we later recognize as the adult form.

Case 1—

The seven-year-old son of a carefree artist who had never taken responsibilities for his family too seriously. The burden of worry about how to make ends meet had made the wife an irritable, scolding and nagging woman whose autocratic attitude had been a seriously impairing factor in the development of the little boy, who had a brother five years his junior. He was a thin, pale, asthenic youngster who most of the time kept his hands behind him, doing nothing, listening to others, or watching with a bored and drawn expression the activities of others. When asked *especially* about what he did and liked to do, one received almost nine out of ten negative answers, always with resentment against the mother in the background for not allowing him to do what he liked and criticizing that he did not do correctly what she demanded. There was a totally depressed air about him which did not vanish even when we had him removed for several weeks into a positive, almost therapeutic environment. An entire discouraged, moody, depressed emotional ground-pattern had already been laid for his mental makeup. There were not any schizoid traits. He proved to be intellectually normal and stood up fairly well in school. However—and this was why even the father had become worried and brought him to me—he had periods in which he started to “act silly.” Both parents reported that the boy, always a moody child, had started to have spells about six months previously. He not only became generally restless, but started to shout and even to sing loudly. He would run around in an aimless, almost infantile, way, uttering an Indian cry, then jump into the air, laughing, and end the running in a circle, stopping and walking for a while aimlessly, only to start the same thing all over again. When asked what he was doing, his answer was, “Having a little fun” or “just playing.” Another one of these “plays” was slapping himself rhythmically

on his mouth, making a howling noise or making rolling movements with his arms and a hissing noise similar to the imitation of a train engine, actions sometimes seen in preschool children during imitation play. Such periods of strange motility and action were coupled with a tendency to excitement, lasting sometimes two or three days. During these periods he devoured food, although at other times he was a bad eater, and was restless and sleepless during the night. After such a period he went back to his usual withdrawn and depressed behavior.

This boy was under my supervision for almost three years. After reeducation of the parents, a positive inner sphere of experience was slowly rebuilt in the boy, which was combined with a regular amount of physical exercise. At the end of my period of supervision, the excitement spells had eased. The boy had definite aims, including a professional plan for later life. He still was relatively solemn, but he was aware and partially in control of his moods. There was no actual danger that he would become an adult manic-depressive psychotic.

Case 2—

The eight-year-old son of a traveling salesman who tried to be at home as little as possible and indulged considerably in liquor and "other fun." He had produced over a period of six years four children, although his wife, had been advised, because of various earlier tubercular attacks, not to have children at all. The mother's weakness forced her to spend considerable time in bed and she tried her best to raise the children with the aid of, or better, under the direction of an older maiden relative who actually ran the four-room household. Our patient was the oldest of the children. He slept, or rather lived, in a small, badly lighted back room, with a bed and a bookcase as the only furniture. The three other children slept in a doubledecker in the housekeeper's room. The entire apartment, as well as the children, was physically incredibly neglected, dirty and smelly. Our boy had no sheets on his bed for months. There was very little concrete information to be learned about his earlier development. He and the next following sibling, who was born only eleven and a half months after him, were reported to be sick during almost all of the early

years. Our patient had many colds and one pneumonia attack as well as three childhood diseases. He had been enuretic up to the age of five and was a very poor, "picky" eater. Quite a few attempts had been made to enroll him in kindergarten and in public school, but after a few days' attendance he was turned back each time because "nobody was able to do anything with him or teach him anything except his father." He had been labeled by the school board as retarded and the father had received permission for private instruction. He was, when I first met him, enrolled in a small private institution for hard-to-train children which he visited approximately twice a week. Most of his time was spent lying on his bed, listening to a badly functioning radio or leafing through old encyclopedias and dictionaries. When at home, the father taught him to read and write and some basic arithmetic. He used his small reading ability to read words and study page-by-page explanations. When given an intelligence test within the limits of the situation, he was found to have an I. Q. of approximately 110. There is no doubt that this boy had strong schizoid traits, but these were not the main features in his mental irregularities. A very specific emotional disbalance is what one has to consider his basic pathology. There was not an hour when he was not very moody, depressed, and negative in all his intellectual responses. He always refused to help or to respond to the mother's or the helper's requests, explaining that they had made "a mess" out of his life and, therefore, they could do everything themselves. Only the father's whipping made him follow any orders. His definite intellectual superiority enabled him to answer back very intelligently, with ironic or negative responses. If awakened out of his depressive inactivity, he enjoyed showing off what he knew; this is what he actually liked doing most of all. However, he had only a very limited amount of mental strength, and after not more than a half hour of this he always dropped back into a depressive stupor. He then wanted to be left alone, ignored any outside activity, and started leafing through his books. He could be persuaded to leave the house only when he went to visit an old mechanic who operated an electrical and radio repair shop in a cellar nearby. He could spend hours watching this man and tinkering with the repair equipment. He

had under this mechanic's direction built himself an old radio from discarded parts. The old man spoke admiringly of the boy's ability to grasp the use of and handle electromechanical devices, but he too mentioned that some days he could not have him around, when "he acted silly or as if he were nuts." In these periods, which recurred almost every week or ten days and which lasted hardly longer than the course of a day, he became restless and excited. He made himself a hat from newspaper or a shopping bag and came out of his room to scare his siblings, and ran around singing and making noise. Down in the shop, he liked to "scare" the old man by misplacing screws or mixing up material. One of the games he played on these "mixed-up days" was that of making funny drawings, an idea seemingly initiated by his father. He sought words having manifold or synonymous meanings and made funny drawings, replacing the correct meaning with the wrong. For example, he illustrated "the man is nuts" by drawing the head in the form of a nut. He placed such drawings all over the house and even tried to place them on store windows, gaining excitement from watching his family and passersby read them. There is no doubt that this again is a form of manic period in a juvenile form, which appeared here as an antidote of depressed states.

Called upon to help this boy, I was unable to do so, since the father refused to have the boy removed from his incredible home environment, and the mother and the housekeeper were unable to change the home conditions, a fact which would have been preliminary for initiating treatment and care. All attempts for personal improvement without this failed. I have seen the boy about ten times over a period of a year without being able to help his condition.

Case 3—

This is the third of three cases which show a certain similarity and which I, therefore, wish to describe together. It is that of a ten-year-old boy who has been labeled as a case of primary behavior disorder; he is in an institution and is actually considered incurable. My information about the history of the boy is based upon a short file report only. The boy came from an underprivi-

leged workman's family consisting of six children, the two oldest of which were girls, our boy being the third child. There was no early physical health history given. The report only stated that the boy had been unmanageable from a very early age and, therefore, had been farmed out when he was five years old. Since that time he had been in various homes and institutions. As regards physical illness, the report indicated only many colds and two attacks of pneumonia.

I never personally treated this boy. I handled a child in the same institution and had on these occasions an opportunity to observe this boy, to which was added information I received from attendants and the doctor in charge. The usual behavior of this boy was to sit in a corner on a chair or even on a table in the day room, with legs drawn up and arms wrapped around his body, motionless, either with the head down or observing the other children. Most of the time he seemed to be in a deep melancholic stupor. Once in a while, when something caught his interest, he got up, sometimes only starting to execute his intention, and sometimes fetching the thing which had caught his interest—a ball with which a child was playing, or a comic magazine which was lying, or had just been placed on a table. He would take the object to his former seat, sometimes looking at it for a moment, sometimes laying it beside him, but losing interest rather quickly. It need not be said that the boy was unable to read. At times he had to be toiletted and spoon fed. He never fought with the other inmates or took part in any group activity. He always got out of the way when anything occurred which caused the other children to gather together. There is no doubt that this child was in a deep depressive psychosis, the only case I have ever seen in such a young child.

Only once a day, and sometimes less often, he would suddenly jump up and start to walk up and down, his face in an expression of severe pain, or even crying. Sometimes he started to run, suddenly stopping and going on the same way. During earlier periods, it was reported to me, these episodes of excitement climaxed in his banging his head on a wall or table. At the time I was able to observe him, he had changed to a less painful outlet, taking a position with his face toward the wall, his hand pressing

against it, and knocking against the wall repeatedly with the top of one shoe, changing from one foot to the other. After going on this way for about an hour, he would suddenly calm down, and fall back into his previous depressive stupor.

Once I asked permission to study such a period of excitement personally and I had him brought into a small doctor's office at the start of the excitement episode. He proved to understand me perfectly. As usual in his depressive state, he answered mostly only with nodding or shaking of the head or with single words. In the depressive period, he also accepted candy or fruit, grasping it quickly, with a short "thank you" and eating it immediately. However, he did not care for any such gifts during the excitement states. He seemed more awakened in this period. All answers given were head shaking and pointing out that he did not feel good and felt always lonely and nobody liked him. He wanted nothing and wanted to go nowhere. He was actually bothered by being forced to talk to someone and after less than five minutes it was impossible to keep him from starting to knock his feet on the wall and crying. I was assured by his attending doctor, a sensitive child psychiatrist, that everything had been done to ascertain that no physical ailment or pain was involved, and that his actions were actually "behavior disorder expressions" which I wish to reclassify here as expressions of a manic episode. The entire case was that of a juvenile manic-depressive psychosis, the only one of its kind I have actually been able to observe in such a severe form. As I mentioned above, I had nothing to do with the handling or the therapy of this case. I also know nothing about the further development of this child.

The following three cases (four to six) are placed together because they have similarity in one important aspect—a speech involvement is manifested in the manic part of the ailment.

Case 4—

This little four-year-old girl was the only child of two professionally active intellectuals for whom the child was an unexpected (and probably unwanted) arrival, but who, after the birth of the child, became terribly anxious and overprotective

parents, overreading any kind of child-care literature and competing between themselves in their solicitude. The house was transformed into a sterilized educational hothouse, and the development of the child was expected to be an ideal of normality. Except for full-term normal birth, good formula feeding, and a perfect first six months, things unfortunately did not quite go the expected way. The child at one year seemed to be annoyed by any overactivity, and developed in the direction of a "serious baby." This was primarily expressed by her refusal to start normal verbal expression. It was established that she understood everything and was able to talk; she simply did not want to talk. The same situation existed at age two, when she walked perfectly steadily and was the most friendly black-eyed doll, ready for a smile, but always questioning with her eyes, almost fearfully, "What do you want?" What she liked most and mostly did was to play by herself. There was nothing of any kind of contact disturbance. She was a very intensive watcher, wishing to observe from a distance those she feared might bother her, but unafraid of strangers who were interesting to her. When I visited the home for the first time when she was three years old, she took a position on the floor a few feet away and later moved to the end of the couch on which I was sitting, fascinated by my beard, not taking her eyes from me for a second. It is, of course, difficult to determine whether the overanxiety of the parents had a definite negative influence upon the development of this child. At about eighteen months of age, she began a certain pattern of reacting against anything she did not like to do at the moment she was requested to do it by starting to cry or to whimper, and could keep this up for hours. The reasons which she used for doing so were often so unimportant that it became evident that this was not a factual but an emotional reaction. She whimpered because she enjoyed feeling sad. There was a kind of infantile depressive pattern in the making. At first it was thought that she wanted special attention, but this proved not to be true. The only way to stop her was to fascinate her by bringing to her attention something which really caught her interest. However, when she was really seriously moody, even this did not work. There was very little progress made in respect to the adjustment

of this child even though any number of pediatric and psychological workers had been consulted.

At the age of two years and eleven months, after having exhausted parents and nurse with hours of whimpering and being placed alone in her bed, she suddenly started, for the first time, to call her father and mother, as well as the nursemaid, by name. She stopped whimpering and immediately fell asleep when placed in her mother's bed. This even changed her basic behavior. It was possible, with great effort, to get individual words out of her, but always after a short period of having her say a few words, she fell back into a deeper passivity than the one preceding the verbal expression, with a frown on her forehead and unwillingness to accept my approach. It was at this stage that I saw her for the first time. There was no doubt that speaking was for this child, for unknown reasons, a tremendously difficult effort. Upon my advice, the child was brought to a nursery school to have her observe how other children of her age used language, without forcing her to any activity. At first she whimpered and did not even want to see the other children; after about a half hour, during which she had covered her face and eyes with her fingers, she started to look through her fingers at them. This experience was such an effort that she fell asleep after a few minutes. The second time she started to watch and actually seemed to enjoy it. This experience brought out the real pattern of her abnormality. She came forward with a much more serious form of general gloominess, refusing to listen to anybody for hours, or whimpering. When brought to the children, she developed a motoric desire which came out in a form of excitement, sometimes expressing the propensity to approach the playmates. Then single words came from her lips, often in attempted imitation of the loud calls of the children. However, these periods lasted only for a short time. When returned home, she always in the late afternoon entered such a period of excitement, calling the names of the parents and repeating the calls of the children. There was definitely a strange form of manic-depressive disbalance in this child. The next step was that we brought into the house a playmate for several hours in the mornings. In the beginning, she ran away, but after weeks of attempts, she accepted

this companion. During this period, she at first did not talk at all to the playmate, but had an excitement period in the late afternoon. A play therapist was called in, who successfully used with both children drawing therapy, which proved to be the solution. Our patient not only took ardent part in this, but started verbal expression when drawing certain objects. The excitement periods in the afternoon became weaker and weaker. At the age of four, she talked in a single-word language with any person she was emotionally drawn to. When whimpering spells occurred, which were not infrequent in the morning, or when any undesired routine procedure had to be done, a short excitement spell followed, which led to a serious tiring and need for sleep. At age five, an almost complete adjustment was achieved. She now spoke in full sentences, but somewhat slowly, and developed into a normal pupil in a private kindergarten-primary school. There is, however, no doubt that her emotional makeup is composed of strong introvert features which must be watched so that they do not come forward in new serious attacks. No such attack has been reported to me up to now.

Case 5—

This four-year-old boy was the son of a young, very healthy and sound white-collar couple, in good financial circumstances. The boy was a physically well-developed, mentally superior child whose evaluated I. Q. would probably have been 130. He had the vocabulary of a child of six or seven. The only difficulty the mother had up to the time she had reason to bring him to me was to keep up with his intellectual demands. When he was three years of age she had to teach him the ABC's, as well as lettering and figuring, which he keenly exercised even during such periods when he came to my office. At the age of three years and eight months, he suffered a severe attack of measles; when he recovered, he remained in a moody, grouchy state of mind. All physical examination, from the metabolic, endocrinological, and other physiological angles, did not uncover a reason for the change in the behavior of the boy, who was formerly so lively. This led the parents to consult a psychiatrist, who not

only did not find any specific pathological pattern, but whose advice did not lead to any improvement. I was the second psychotherapeutic worker consulted. Besides the depressive moods, he had suddenly developed temper tantrums which were associated with stammering spells lasting often for a couple of days. I learned that up to the time of the visit of the psychiatrist, the quite fearful and overprotective parents had applied only persuasive means to lift the boy out of his depressive spells. The psychotherapist first consulted, who feared that this attitude would only soften the child and result in his misuse of their willingness to give in to everything, had proposed a more definite punitive parental attitude. The boy was considerably shocked by this change. He made no actual scenes when he was scolded, but frequently started to cry. But, seemingly inside, in his disbalanced emotional sphere of experience, this created a kind of manic pattern. About twice a week, on actually insignificant occasions, he had a violent temper tantrum, which always ended in a crying spell lasting for quite some time. In building up towards the temper tantrums, he started to stammer and this stammering could last long after the tantrum spell had subsided. This was, in my opinion, as clearly a case of the manic-depressive disbalance in an infantile form as I have ever been able to observe. The therapeutic task was an unusually difficult one, the greatest problem probably being that the onset had been caused, or at least climaxed, by an initially incorrect therapeutic attitude. First the relationship between the child and parents had to be normalized and a long and rather detailed parent-education adjustment had to be achieved. It took almost three months before the intelligent little boy regained his full confidence in his parents. Not before then was it possible to start to lift him out of his depressional tendencies. We found that he already had developed a certain attachment to his stammering pattern, which gave him release and protection at the same time as the manic spells had already lost their significance and were ceasing to recur. We, therefore, had to enlist the assistance of a speech therapist, a fact which in itself again created resistance desires in the child. It took over a year for the entire episode to be eliminated. There

is, of course, great need for such cases to be carefully observed for any tendency of recurrence. When I last saw the boy, he was ahead of his entire public-school class in the second grade.

Case 6—

This is the case of an early-maturing colored girl of eleven who started her menses half a year before we saw her first. She was the eldest of five siblings, all born in about two-year intervals to a light-skinned Negro couple. The father, a husky, noisy fellow who drank without actually being an alcoholic, had a small cleaning establishment in the front of a cellar apartment which originally may have had only two rooms but which was now partitioned up into a number of terribly unclean cubicles in which this large family lived. The mother was a small, always sadly smiling introvert, a doubtless depressively sick person, who tried to raise these children as best she could. There was hardly any definite information to be obtained about the past of our patient. She supposedly was normally born and was breast-fed for quite a long time. She developed normally but had lots of sicknesses—"mostly colds and baby ills"—as the mother called them. She was always shy and a cry-baby, but otherwise "a nice kid." The family lived in a tense, semi-Negro section of New York City, and the child had no other play space than the street. From early childhood she was the maid for the family, seemingly always tied to the doorstep because she was hit if not on hand to help or run errands. There was not much interest in having her attend school and during the first years the school authorities constantly sent truant officers to attempt to enforce her attendance at public school. The girl was now enlisted in a Roman Catholic parochial school which she attended irregularly, although the parents were not of that faith, but registered her there because "the nuns were more considerate with the girl." According to the crude routine testing applied today by most public-school psychologists, the girl tested an I.Q. just above that defined as mentally retarded. Our testing methods showed that, under the best conditions, she could register an I.Q. of 85 or 90, but under the influence of her depressive state, she probably tested only 75. There was no doubt that she was a case of educational retardedness

and, in any case, a slow learner; because of this, the public-school system did not want to cope with her. In the parochial school she made slow progress and was in the third grade, although she probably should have been only in the second. The child was presented to me as a case of severe stuttering with which a speech therapist had failed, maintaining, correctly, that the entire condition had a psychopathological background. The girl was a friendly, undersized child with a sad expression, who answered slowly and was greatly hampered by her speech pathology, which seemingly always appeared at any first contact or any momentary new experience. After a period of therapy, the stuttering would disappear, usually completely. The first answers received from this child were depressed and negative, relating to the bad life she had, how she was hit by her parents, and her annoyance by siblings. However, as soon as positive suggestions were injected into her mind, she changed immediately—her eyes started to sparkle and everything was wonderful, particularly if talk was about the future. Her greatest ambition was to go to high school and later on become a teacher or nurse, and "to help poor little children like the Sisters do." There is no doubt that this girl was an emotionally high-strung and labile child with not much, if any, ego stability to give her control of her emotional experiences. Nevertheless, she was not a schizophrenic because there was a definite continuity in all her mental expressions, without contact breaks. But we are not justified as yet in presenting her as some kind of manic-depressive type. This comes forward in the definite periodicity of her emotional disbalance. As the mother reported and as we saw her after treatment had been initiated, she had days and weeks during which she seemed to be a normal child, a little slow and thoughtful, but with normal emotional responses and without the slightest sign of stammering. There came, however, periods of depression lasting a week, during which she was always near crying, did not want to go to school, was hard to get to help at home, and sat mostly somewhere in a kind of stupor, "watching things." In these periods she stammered only slightly and was able to express herself slowly with a certain muscular effort, later eased by the therapeutic chewing method to enable her to begin to speak. In these

periods, however, she did not like to talk, and it often took ten to fifteen minutes of therapeutic influence to make her shift emotionally to a positive attitude. So far as we were able to establish, these depressive periods were not caused by really unusual and serious incidents, but "came on anyhow" started by any common occurrence. We were also unable to establish any connection between her spells and her menses, which were one-day affairs with very small amount of release and came irregularly, mostly eight to ten days late. Almost every time at the end of such a depressive period, she went into a severe spell of restlessness, during which she actually built up a stuttering pattern. She could become so excited that she ran out of the house and screamed, was completely unmanageable for several days, and reacted poorly even in treatment. Of course, during these days she was unable to attend school. After the storm, she calmed down very suddenly and had her "normal period" for a few days. However, and this is the specific on this case, she continued with her stammering-stuttering pattern, which actually had to be broken by therapeutic influence. It appeared as if she worked herself, during the manic spell, into a routine pattern in regard to her stuttering, which she used as some kind of emotional escape and which she had great difficulty in stopping. As we mentioned before, she always had a slight stammer when she met any unusual situation, a new person, or any slightly embarrassing or upsetting situation. I have supervised this case for almost two years, working with a speech therapist and a female psychotherapist toward whom the girl proved to have a stronger leaning than toward any man. However, during this period, not only because of the bad environment with its permanent episodes of an upsetting character, but also because of the seriousness of the case, only partial improvement was achieved and I must refrain from any prognosis of the possibility of a more or less complete cure.

The following are cases of adolescents that have been selected from a larger number that I have seen and have attempted to work with therapeutically. I present these four cases here because they, in my opinion, shed light upon the problem of recognizability of a juvenile manic-depressive soma. These cases are also

specifically chosen because of the possibility of discussion of the problems here from various differential viewpoints.

Case 7—

A thirteen-year-old boy of German descent, stocky, red-cheeked, and a little overweight. He looked the picture of health itself, except for his "doglike, downward, overobedient look," expressing immediately the discouragement which was the main feature of this boy's mental attitude. The father was a broad-shouldered maintenance man, a sworn anti-alcoholic, and a life-long rheumatic who was able to work only part of the time. The mother was a sound, but worry-strained German "*Hausfrau*" who helped finance the family by working as a house-superintendent. There were two girls in the family, one two years older and one three years younger than our boy. He hated both of them heartily. The younger, a tomboy, got everything she wanted and picked on him constantly. The older teased and pitied him because of his clumsiness. The boy went to public school, in his correct grade, and had just always missed being left behind. The mother brought him to us because of recent, as she called it, "obsessions." She was quite worried and blamed this on masturbation, as she told me in his presence. According to the mother, he was a normal baby, breast-fed "in the old style," and normal in everything until a year or so ago. He had a few childhood diseases and his tonsils were removed at about the age of six, at the suggestion of a doctor to fight frequent colds which bothered him for several years between five and seven. Up to two years ago, he was a perfectly normal-acting boy, with the specific aim of becoming a mechanic. After school he hung around nearby garages and an electrical shop, and he had a boxful of tools and mechanical devices which he carted around. But trouble started that summer when (this was what the mother reported) the younger sister got a free place in a summer camp and he had to stay home. Seemingly this was also the time of the first signs of his maturing. He started to complain all the time and "got always in the way of the parents." Hit by the father, he started to vanish overnight and even for two-day intervals, and when he came home he actually did not quite know where he had been. He was

moody, answered back, demanded to be left alone, cried easily, and talked to himself. At first it was difficult to establish any contact because he was in a complete cloud of distrust; not until the third visit was I able to win his confidence and get him to talk about himself and his problems. I learned that he had always felt neglected in the family; that he had never had a real friend to whom he felt able to talk openly; that, especially in recent years, he had felt the need to talk to someone, but that each attempt he had made to talk to teachers, a young Lutheran clergyman, a counsellor in school, had always led to the same feeling of not being understood and being ridiculed. For the past three or four years he had never felt happy, but had dragged himself along and had tried to be friendly and to make no trouble at home. His remark, "They have it difficult enough" showed that he was sincere in his feeling, even against his hated sisters. Increasingly during the past two years he had felt that he was more and more unable "to hold his own"; that he was less and less able to control his feelings of depression and moodiness. He found himself daydreaming about his hopelessness and even had, on some special occasion about which he refused to tell me, thought of suicide. He mentioned that on some days he felt worse and on others better. His strongest emphasis was on his inability to control his depression, his feeling of "sinking deeper in it and being unable to control it." He had no answer for questions as to why he wandered away from home and where he stayed: "I just could not stand it any more so I walked around." This was, as he expressed it once, "still all right." The worst was when it "got him." This happened once in a while for a few days, when he got especially restless: "I felt I should scream, do something. I felt that something was going to pieces." He sometimes had headaches on these days and stayed or got away from school. In these days especially he felt such a pressure in his sex organ that he could not help but masturbate. "My mother found me out once or twice, this is the reason she thinks I do it all the time." (Any interest in girls was ruled out by his hatred of his sisters.) In these spells, which definitely were manic, he was always terribly thirsty; he often knew, by the coming on of such a thirst, that he "would be going crazy again for a day." His worst fear seemed to be that

he would lose interest, and with it the belief that he would not be able to learn and properly execute a profession. We helped this boy first of all by re-educating his family, then by giving him positive human relationships and by rebuilding in him a positive emotional experience. He was considered cured after six months.

Case 8—

A Puerto Rican boy of fourteen. His father was killed in an accident in Puerto Rico when the boy was two; a year later his mother immigrated with him to the United States because of a promise of support by her mother who had come to this country earlier. There was a history of normal prenatal circumstances, birth, and infancy. After being in the United States for two years, the young mother decided to prepare for earning her own livelihood and enrolled in a photography school to become a photographer. The boy was sent to nursery school and later to kindergarten. The mother continued her professional preparation with work for a photo studio. She used the boy, who had developed into an unusually beautiful child, as a model for children's-advertisement photography. She apparently became really successful, since not only was she able to support herself, but she was able to put money aside for starting her own photo studio. She was about to do this, when at the age of seven the boy was hit by a car and his face was badly cut and deformed. This destroyed many of the mother's dreams and formed in her a serious resentment against the child. When telling me the story, she exclaimed unreluctantly, "If it had only hit him on his feet or somewhere else and not deformed his face." There was no doubt that she actually started to hate the boy. She again and again subtly and openly scolded him that he was a bad boy, that he had ruined her and his future, etc. The boy actually had not suffered much of a mental shock from the accident, but the permanent heckling by the mother certainly was a seriously depressing element which during the following years became the basis for a severe mental depression. According to the report, he was a bright, lively youngster who, after leaving kindergarten, went to public school. He had been an average, normal student until the

accident occurred. To the negative attitude of the mother were added rude insults in play by school comrades and remarks by people on the street regarding his face, which increased his hurt feeling. Time and again he had to fight against being given the nickname "Scarface." After the mother finally succeeded in getting a studio set up, she did not even want to have him around much because, as she maintained, her business would be hurt since people would be scared to see his face. He had to sneak in by the back door and take, day in and day out, the brunt of her emotional upsets. He matured early, at the age of eleven, and found, in addition to the already existing social trauma, that he was unable to approach girls, who would not tolerate him because of his appearance. He started to masturbate violently and this, it seems to me, was the start of an actual manic-depressive syndrome. He had already, a year or two after the accident, started to fall behind in school. He had tried to compensate for the negative social attitude by trying to be good at sports "so that the boys would want him for the ball games." But there was no other real compensation than to daydream. He was now in high school. Shortly before the school counsellor sent him to me, he had been threatened with being left behind in his grade because his marks had fallen so badly below acceptable. This had led to truancy and the desire to quit. All this turmoil had brought on a serious depressional pattern. He cried during the nights and sat home alone in a back room "in a fog." About twice a month, after a night or two of nightmares and wild dreams of being accused and chased, he entered a manic spell. He became, in these days, "fresh" to his mother, she reported. He found satisfaction in assailing friends and strangers with bad words. He carried in his pocket the neck of a beer bottle with sharp edges, waiting to get the courage to use it on someone's face. He had used this bottle-knife on the walls of the rooms at home and outside as well, on houses and trees, also on pictures of girls. On the other hand, he was "afraid that he sometimes would do such a thing" and "when he felt that way he knew that being bad off was about over." In such a moment, he spoke openly to the school counsellor, who immediately realized that the boy seriously needed help. During his first visit to me, he boiled over

with self-accusations and depressive guilt feelings towards his mother. We told him of plastic surgery and got him in touch with an institution where he soon was taken under treatment. I asked him to show me the manic bottle-neck fetish and when I asked him to give it to me, he expressed relief that I wanted to keep it. In regard to the erotic troubles, we contacted a young nurse who agreed to help in this attempt at a cure and whom he saw twice a week after school hours. The most difficult element proved to be the mother, whose education in accepting the boy with a positive motherly attitude was an extremely difficult task. Improvement in school marks after a few weeks gave us hope of success for the cure, and after a year, with skin grafting under way, the boy was himself on the way to cure.

The last two cases reported here are added with some reluctance because both are rather complex pathological cases in which the manic-depressive symptoms are only a part of the total picture. However, since I have never seen anywhere else the specific manic-depressive character I wish to describe here, I am presenting the cases. In the case of the girl, organic and severe phobic elements are definitely basic involvements. In the second child, a mild but pronounced form of schizophrenia is involved.

Case 9—

The eleven-year-old daughter of a woman of Near Eastern descent. The girl was born out of wedlock but was told her father died when she was a baby. The woman had all her life earned a small income from needlework. The girl, according to the report by the mother, was normally born, breast-fed for a very long time, and developed normally. She had most of the childhood diseases, including scarlet fever, and had twice broken bones (once an arm and once a collarbone). Tonsils were removed when she was seven. The girl was kept home until public-school age. She developed into a dull, somewhat restrained youngster, partly due to the educational attitude of the loud, noisy, and talkative mother, who had "had enough of men" after "the one experience" and doubtless implanted fear of the opposite sex and

of public contact in the girl from the earliest days. The girl was not permitted to go to school alone and had to be accompanied by another girl, preferably older, and had to come home immediately after school. She was always kept in adult company and was never let out on the street alone, except to do some errand at the grocer's across the street, the mother watching from the window. The pattern of the daughter of the poor widow and the premise that all men are bad were basic imprints of her emotional life. Her low grades on her completion of public school made the teachers suggest enrollment in a vocational high school. The mother met this suggestion with great resistance because the child would have to travel to school by bus, but finally agreed when an older girl living nearby and attending the same school was found to pal with the daughter and accompany her to and from school. This girl became the tragic factor in the child's life. Our patient had started menses rather early, at eleven years, and had a rather strong, femininely developed body with over-mature secondary sex characteristics. Her only knowledge of sex was poor information given at the start of her menses, until she started to become "introduced" by her high school comrade, who at the time was sixteen, but who had had real sex relationships with various boys and men since the age of thirteen and who now had a standing relationship with an eighteen-year-old sex delinquent. This boy wanted the girl to get him young girls for defloration. She invited young girls to the vacant apartment of her parents during the day and while she watched outside the door of the room, the boy tried to rape these children. Our patient was subjected to such an attack about ten months after she had started to menstruate. The day following the attack, she succumbed to a nervous fever lasting for almost a week, with 48 hours of unconsciousness. The shock stopped her menses from that day. She continued having nightmares and developed momentary crying spells, during the day, refusing to go to school and to see that girl again. After several weeks, when reliving part of the rape experience in a nightmare, she half-awakenedly confessed to her mother what had happened. The woman was so shocked and ashamed that she actually supported the girl's phobic attitude. It was after a half year of treatment, when observations

led me to hint of sex delinquency, that the mother confessed the experience of her daughter to me. Over a period of two years, the girl was on a steady decline. She refused to leave the house, even wanting to be assured that nobody was in the adjoining room or in the bathroom before she entered. She saw men on the fire escape, had depressive weeping and crying episodes, and refused to undress in the light or in front of a doctor. The mother finally became so scared that she consulted a practitioner, who sent her to an endocrinologist, and finally a psychiatrist entered the picture. There was never a restoration of regular menses or anything else achieved to return the girl to a level which would have made possible further intellectual training. I have never been able to receive information regarding the type of therapy used (I believe there definitely was application of certain drug treatment) in making her overcome some major parts of the claustrophobia and in developing willingness not only to help the mother, but leave the house with her and stay with her at a workshop, where the mother had recently taken work in order to meet the expenses for treatment of the daughter. The girl stayed with the mother all day, helped "a little," carrying material and assisting in stock-clerk work. However, there still existed a permanent depressive pattern which it seemed impossible to remove. In addition—and this is the most important element in the somatic picture—"exactly every four weeks" she entered an excitement spell. When this started, she began to "act up and be silly"; as the spell continued she bit her lips and cramped her hands together or grasped her clothes; her need to hold onto her mother was denied by the mother. At the peak of these spells she screamed suddenly, maintaining that she saw a man standing somewhere or walking with a threatening gesture toward her. There is no doubt that this change from depression to excitement pattern is a specific type of manic-depressive soma. Further, there is no doubt that the manic episodes in this case have a certain connection with the periodicity of the menses which, for psychosomatic reasons, did not function normally. After coordinating treatment by an endocrinological specialist and deep psychotherapy for over a year, the first irregular menses symptoms started to appear. There is great doubt in my mind whether this

girl will ever be able to be restored to full normality, but major elements of the phobic conditions have been removed and the manic-depressive pattern considerably eased.

Case 10—

This is one of the most pathetic cases I have ever encountered in my lengthy experience in this field. At the time I met this boy, he was fifteen years of age. The parents had met each other when they were students attending the boys' and girls' division of an institutional school for unsettled youth. When they were graduated and released for home, they started dating and had an affair; seven or eight months later, they produced this boy. The father at the time was eighteen and the mother seventeen years old. The parents of the girl lived in a dirty cellar apartment of a large tenement house in a slum area, of which the father was a kind of superintendent. The girl had been very difficult to manage since she was a youngster in elementary school, and because of mistreatment at home had been institutionalized. When the pregnancy became noticeable and she had to confess to her parents, the father invited the boy to the home and beat him cruelly until he agreed to marry the girl. He was locked in a back room until preparations for a religious wedding ceremony were made. Three days later he disappeared, and had never been found again. The parents made it as hard as possible for the girl, their only child. Even when the little boy already was of public-school age he had to hear the parents refer to his mother as "our whore" or "our bitch." The boy was born in the windowless back room in which the mother and son still lived when I started to take care of him. Pregnancy, birth, and early development were normal. About a year after the birth of the child, the mother took a low-paid job and was still working with the same firm, under slightly improved conditions, when I met her. She had developed into a serious-minded and very trustworthy worker who paid her parents "in full" for room, board, and taking care of her child. The boy was handled by his grandparents in a way that could only be called cruel. He told me that as far back as he could remember there was not a day when he was not hit with a strap. He related that the grandmother occasionally would re-

mind her husband that he had not yet whipped the boy, and the grandfather told the boy that he needed the whipping so as "not to become as bad as his mother was." He was kept in the house or in the back yard until the age of seven, when the school authorities started to check on the reasons for his not attending school. Long before that age he already had to help with the housework and run errands, not only for the grandparents but also for other people whom they wanted to please. He never was called by his given name, but was always addressed as "Boy." If anyone gave him a few cents, he had to give it to the grandfather who would put it into his own vest pocket. The only "good time" he had was when his mother came home in the evening and they both retired into the back room or when she took him for a walk. Comic books which she sometimes brought him were torn up by the grandfather; once she brought a small table and chair for him to sit on and read and do his homework, which the grandfather took out the next morning and broke to pieces, maintaining that "such stuff was unnecessary." The mother was able to stop this attitude only when her earnings increased a little and she threatened to leave the house and rent a room somewhere else. The boy grew into a slender, pale youngster. He had the usual childhood diseases and frequent colds. He was definitely undernourished. The roughness of his childhood years emanated from his eyes, which had a scared, feverish look. When I met him, he had a permanent tic-like twitch on one side of his mouth, which seemingly always had replaced his smile. His preferred position was sitting hunched up on a low chair, his crossed arms and legs hugging his body, and holding a newspaper or magazine with the hand near to his eyes—a strange position, almost prenatal in character, as if he wanted to take up as little space as possible. His school record greatly puzzled his teachers because he never measured the same I. Q. with the conventional testing means, several times averaging 125, and at other times registering as low as 90. He always appeared moody, unable to concentrate, and restless, but schoolwork "was no trouble with him" and he was always high in his grades. Nevertheless, he was a disturbing element, "without actually doing anything." There were all the features of permanent childhood depression, but

there were also symptoms of schizophrenic involvement. There were the characteristic motility frustrations and the withdrawing and paranoid phantasy symptoms. Since the age of eight, he had been begging his mother to move from the grandparents' home. When at about the age of twelve, he stood up against the grandfather when he wanted to hit him and fought back, the old man once became frightened, running to the police and filing a complaint of delinquency. From that time on, conditions were a little better; at least the boy was able to stay by himself and read, the only pastime he actually desired. He had no friends and no actual ideas for a profession. Asked, when I met him, what he wanted to be, the first answer was "to get out of where I am in" and further similar questions elicited the same type of answer, in addition to the comment, "I guess what most kids want to be is some kind of mechanic." There was a permanent battle between daughter and parents about the conduct and education of the boy. When a decision had to be made at the completion of public school, the grandfather, who was the boy's custodian, wanted him to "go to work at once and bring some money home." The daughter went to the authorities and won out that he should continue with a high-school education. Unfortunately, he was placed in a high school where he was the only member of his national group among a majority of strongly nationally opposed youth. This increased the unfortunate pathogenic conditions to a catastrophic degree. At that time he was sent to me by his school counsellor, who felt that the boy was in a state of "serious mental danger." This danger was observable not only in the obvious permanent depressive state the tall, nervous boy was in, but in "strange" occurrences which (to point this out in advance) proved to be an odd type of manic episode or the most pronounced part of it. These episodes occurred when something was about to happen in the boy's life which for him seemingly or actually was of great importance or much desired; then, just before the event was to occur, he did something "crazy" which indicated the tendency to destroy or avoid the realization of these badly wanted events. For example, he badly wanted to learn to play an instrument to enable him to become a member of the school band, as an expression of his

desire to have social contact. The morning of his first appointment with the music teacher and band leader, he had such an upset in class that he had to be restrained and presented to the school principal, and the favor of music instruction was cancelled. On another occasion, the mother promised to take him to a movie in the evening and asked him to shine her shoes and prepare a few other things; he promptly ruined her shoes and created havoc at home. Asked, under treatment, why this happened, he, with his pattern of self-punishment, ironically remarked, "I probably did not want to go or was too excited." I tried to get him to go to a party with another boy and to meet some girls. He started to prepare his clothes preceding the event, but shortly before the boy arrived, he ripped his only white shirt and offended that friend so that he left without him. When I finally succeeded in arranging his transfer to another high school, two days before this would have taken place, he decided to take revenge on his class by starting a fight with the weakest boy in the group. The two boys used rocks, then pocket knives on one another and, in a seriously wounded state, were turned over to the police for presentation in the children's court. He was detained and placed in a youth hostel. When I visited him there and promised him that I would succeed in having him paroled into my custody the next day, two hours after I left, he tried to slash his wrist with an instrument he had picked up. During the most serious of such spells, he had attempted suicide three times. Most of the attacks followed about the same pattern. They started with a rise in emotional upset beyond the level of the prevailing depressive state. For hours and sometimes half a day in advance, there began a restlessness which was not only a disturbance in motility but in the total personality. He maintained he could think less clearly during such an onset than he usually was able to. He had the desire to jump up and started to tear his fingernails and the skin around them, and had the compulsion to shout or sing and make rhythmical movements with his legs or entire body. He felt a rise in his sex impulses. Then a stage of anxiety arose regarding what should happen next; he thought about it, and then became so excited that he actually lost control of thought and actions. He felt that

something ought to happen . . . "and then something did happen"—what, he did not know. After this climax had been reached, he suddenly dropped into a deep depressive stage, actually psychotic in character. He no longer wished to be alive and in moments, when strength still prevailed, desired and even attempted suicide. Mostly, these periods of manic excitation with their depressive endings closed with restless sleep, crying, and nightmares. When he awakened, he was back in his normal depressive state, remembering very well what happened and filled with great remorse. We had been wondering whether these attacks might be in the line of seizures, for instance, of petit mal. However, an E.E.G., twice taken with the assistance of a psychiatric and neurological associate, did not support this hypothesis. Therefore, I came back to the assumption that we were dealing here with a very specific form of a manic-depressive spell.

Much more could be said about this last case and our report could have been extended quite a few pages by giving greater detail and various different aspects; however, because of economy, I have reported here only what I felt to be necessary. In conclusion, it may be said that this boy was assisted by me over a period of four years, with the result, when I last heard from him, that he in due time was able to enlist voluntarily in the U. S. Marines.

DISCUSSION OF THE CASES

In the discussion of the ten cases I have presented here, I feel it must be emphasized that we cannot apply views formed about adult depressives as a general basis of consideration for juvenile depressive and manic states. The adult picture in its present altered form and definition by current American psychiatry as being mostly a state of psychosis is in itself not useful for a sound application in relation to the juvenile picture. Up to the present time I have heard of or seen very few actually psychotic children who would fall into this category, and it is questionable how far we can apply our general concept of psychoses to children. Of the set of the ten cases presented here, only one (case 3), that of the institutionalized boy, can fall into the category of psychotic; cases 9 and 10 are border-line cases manifesting psychotic traits.

Usually all cases of emotional disturbances, which I am designating here as manic-depressive, fall into the category of neuroses of various degree and kind. This is the primary difference between our concepts for adults and those for children.

However, to find a general basis for what we want to discuss and present here, I should like to emphasize again that I feel it would be best to go back to the original concept of Emil Kraepelin (126). To him, any manic-depressive ailment was a disease of "*des ganzen Gemuetslebens*" (the total of the emotional sphere of the psyche) with various expressions in the one or the other direction. Since it is a basic law of our emotional life that it is always reacting dualistic-contradictorily, positive-negative, low-high, etc., and the pathological character exists when there is an extremity and exaggeration in either direction. Accordingly depressions are manifestations of emotional lows, and manic states expressions of emotional highs. If there is a characteristic picture of manic-depressive illness, it is that of an interchange of both of these stages, sometimes with an eventual lull in between resulting in periodic calm. There is another aspect in Kraepelin's observations which seems to us important to consider, and which we have already mentioned and wish to emphasize again—namely, that those who later in life become psychotically sick manic-depressives have a history, dating back to their youth, of depressive moody behavior which was easily observable, although an actual manic pattern was hardly noticed by those who lived with them.

This is where my thesis begins—namely, that with properly developed view and insight we may clearly observe these manic spells in their prepsychotic juvenile form which, if properly understood, can prevent their changing into a psychotic pattern later on. This may be considered as a rather wide and abstract scheme, but as such it may help us to broaden our scope. We know, of course, that such developmental factors do not always occur and in reality hardly ever appear in this general form, but usually occur in a very individualized pattern.

In viewing our ten specially selected cases in regard to conditioning of the illness by environmental and physiological factors, with reference to home environment and family setting, one will

find in almost all of the reported cases a certain amount of unsettled conditions, ranging from mild to rather severe, which doubtless have played a considerable part in the development of the onset of the symptoms. From a study of a rather large number of cases of infantile and juvenile depressions, I can report that a very high percentage of these were negatively influenced by environmental factors. However, this fact in itself cannot lead to the final generalization that this is the only causative factor. All these children had an innate conditioning or additional conditioning factors which led to their depressive or manic ailment. We note that most of them had siblings who were not subdued by such disease.

As regards physiological background for such emotional disbalance, I must report that from my observations I have found this to be negative in the juvenile stages, particularly in regard to constitutional conditionings. I cannot agree with those who believe they have found in Kretschmer's (127) constitutional typology or Lange's (130) metabolism, a key to tendency to depressive disease. I have not only in these ten selected cases, but in all the cases which became known to me, found very few which correspond to the theory of Kretschmer's typology. There are also only very few instances where physiological conditions have proven influential in the development of a specific juvenile manic-depressive condition. The moodiness and grouchiness of those children afflicted with juvenile hepatitis, to report on a pathogenic observation of my own, do not have a tendency to develop into such specific depressive cases, but have certain pathological features of their own. Also, the tendency to certain endocrinological or metabolic deviations has not been found to predominate to such an extent as to consider these primary conditioning factors. (All the cases reported here were medically checked during my handling or were under permanent medical treatment.) Prematurity or retardedness also cannot be presented as a conditioning factor for more than a very few individual cases. Finally, only in a very few cases could we find participation of other mental conditions, for example, schizophrenia. As mentioned in the introduction, this manic-depressive soma has a syndrome of its own and we must even dispute in

certain cases earlier labeling as schizophrenia or behavior disorder, after the establishment of these definite characteristics.

Speaking here about a specific emotional disorder, we must first attempt to clear somewhat the confused terminology surrounding this condition. It has been only less than a decade since emotional factors have been considered to have real psychological meaning, as has been established by the majority of American psychologists. Before then, since the beginning of this century, emotions and feelings were banned as prescientific fairies by the behavioristic school. Nevertheless, I still do not accept the concept of emotions as a psychologic-behavioristic one, as for example, does P. T. Young (185) and others. I must refer to my own description and definition of emotion and feeling as I presented it during the Mooseheart Symposium on Emotions and Feelings (92), which leans in the direction of the pre-behavioristic concepts of Hoeffding, Janet, and the psychoanalytical leaders. It represents an introspectively felt inner dynamic experience of being inwardly moved and by it is evaluated the rest of our empirical experience. The sphere of our emotions and feelings can be experienced and studied independently or autonomously; nevertheless, it is in some way interconnected with the physical part of our existence. I must here come forward again with the old deep-psychological contention: the suffering of these emotionally sick children proves the reality of what they, and we with them, can inwardly experience.

In trying to understand these emotional deviations in children, we will do best to turn first to the one kind which seemingly is the more frequent, that of *depressions*. Depressions mean that the negative factors of emotions and feelings become a permanent state of mind. This often reaches a degree where there is no longer any control over their predominance. They have habituated themselves so deeply and permanently in the psyche that the person in this state is only with great difficulty, if at all, able to replace them by his own will and reaction with any positive emotional capacity. Most emotional sickness, considered from this viewpoint, means lack of control and inability to self-direct emotions and feelings. Being depressed means that a person no longer has the ability to shift "naturally" to a positive emotion

or feeling, like being happy or gay, and remain in this state of mind without any effort. A depressed person automatically sinks back into a negative emotional state like unhappiness or moodiness after the forced state of feeling happy has to be given up. In more severe cases, the capacity to shift to positive emotions and feelings and experiences has become completely paralyzed by negative emotions. Such a person can no longer feel happiness or gaiety; he has sunk into a severe state of melancholia.

Those who, as for instance, Henderson-Gillespie (97), have studied adult depression in great detail, had to separate and differently describe a considerable number of types of depressive diseases. If one surveys our selected ten cases, one would not find much reason for such differentiation, except in regard to the last four adolescence cases. The reason for this is that depressions do not appear in childhood in such a differentiated form as they appear later on in the fully grown. It is this which has led more superficial observers to the belief that depressive and manic-depressive states do not exist in childhood at all. Our own concept of the development of the human mind and psyche as well as of the total nature is that it is a slow process in which we can very clearly designate certain stages. As a young child physically at a certain point in his growth develops his first and second set of teeth and reaches the maturity of his reproductive organs, so the psychic nature of man has certain stages of development and maturity, which I have discussed elsewhere from various angles (78, 85, 86). We can clearly discern a maturity stage of the "I" or ego at about the age of three or four; a second similar maturity stage of the emotions and feelings sphere at the age of about seven or eight; and finally, a maturity of the will-nature which coincides with the maturing of the reproductive organization. The realization that a child below the preadolescent stage of seven actually has not yet reached a mature emotional sphere makes understandable why he cannot as yet show such a variety of emotional expressions and, if diseased, a variety of pathological possibilities as does an adult. A young child has only a kind of embryonic emotional life, but this also can be, like the fetus, afflicted by illness. Emotional premature experiences are, of course, evidenced by a baby's cry and

smile, but the actual simplicity not only of the healthy, but particularly also of the sick emotions points in the direction of these facts. However, the more experienced observer will find that in emotionally disturbed children, there often exists a kind of prematurity and unhealthy advance beyond the point naturally expected. This is similar to the senility of defectives. In their negative emotional states, these children seem to be emotionally more mature than they should be, which fact actually is an expression of the pathology itself. Such prematurity was most clearly observed in the case of the institutionalized boy (case 3).

If one follows the actual emotional development from babyhood, one must say that before actual ego maturity, a child's emotions are only very primitively experienced. They actually are expressions of physical pain and physical well-being, and sensations like being tickled, which means they have the character of a sense-perception. It is very difficult to go beyond what I stated in the introduction regarding the so-called "serious baby" in making specific observations regarding depressive pathology in this earliest stage. However, we intend to emphasize later on, some not too rare manic expressions as we have found them to exist.

After ego maturity is reached and the child has discovered himself and starts to respond by calling himself "I" rather than by given name, we clearly find emotional experiences, but again, as yet, the child does not experience what an adult experiences in the sense of emotions and feelings. In a child at that stage of development, emotions are actually only self or ego mirrorings. I can never forget a scene I once experienced with an unusually bright and wholesome little girl who had entered her first phases of ego experience. She was sitting in a corner on the floor, sobbing with great distress, without any apparent reason. When I asked her what was wrong and what she was feeling to be so sad, she answered, "I feel that I am feeling sad."

A more clear definition of the meaning of these emotional ego experiences cannot be coined. The child feels in himself his sad or joyful moods. Our cases 1, 4, and 5 were examples of this stage, particularly the little boy described in case 1, whose facial expression was always unhappy because he felt so badly treated;

also, the little girl in case 4 was sorry for herself because so much was asked of her and so much was done that she did not want, therefore, she disconnected herself from her environment and simply did not want to talk. Such childhood experiences, rather difficult to comprehend, can be quite easily understood when approached with such a correct understanding of developmental interpretations.

A child matures emotionally when his emotions and feelings become entities with which he can evaluate and judge personally all his other experiences, especially those made in contact with the outer world. Emotional maturity means an actual subjective, introspective understanding. The German language, which is especially rich in expressions defining the emotional life, not only speaks of feeling—*"Gefuehl"*—for the actual dynamic activity, but also of *"Mitgefuehl"* and of *"sich einfuehlen,"* which, literally translated, would mean "feeling with," "feeling experience," expressing the actual feeling of some fact or object outside one's own existence, for the purpose of defining any outside experience properly. This ability indicates a mature emotion or feeling, and this a child is able to advance only after his actual emotional maturity has been reached.

Maturing in itself is, as we know from adolescence, not only quite a serious experience but also one which can lead to serious developmental conflicts and actually to a crisis. We have instances in our cases 2, 6, and 7 where apparently the emotional maturing did not develop in the natural and healthy way. Such children actually have contact problems and contact disturbances in properly dealing with experiences coming from outside which they are called on to tackle with their maturing emotions. These children may appear to be and probably frequently are on the border line of schizophrenia, but in no case show a clear pattern of schizoid conditions. If the crisis is not overcome, they may develop into actual schizophrenics with a schizoid type. Children who have been permanently beaten down or upset during the period prior to emotional maturity are apt to become serious cases of inability to mature normally. The boy who lived most of his days in the back room (case 2), the stut-

tering girl (case 6), as well as the fat boy with the hated sisters (case 7), certainly had no sound preparation and circumstances for normal emotional maturing.

In our attempt to understand such juvenile depressions, we must also realize that the preadolescent period is the most important and the most difficult for the child. We usually place all emphasis on juvenile difficulties in the direction of adolescence. We are carried away by our adult viewpoint in regard to maturing to live. A child's development follows its own way and its own patterns. And here, the emotional maturation stage is almost more important, psychologically, than the adolescent maturity with its social aspects. The most important and at the same time the most misunderstood point in this emotional maturity stage is the fact that a child does not yet have the adult manner of experiencing emotions. He still is more occupied in building up and exercising his emotion and feeling capability than in using it maturely. Children, therefore, have a great tendency to defending themselves and retire from overusing their not yet completely developed psychic abilities. We mentioned before the "*Trotzperiode*" or "defiance period," that stretch of juvenile development where children are apt to say "no" more easily than "yes." It would be the greatest step in practical understanding of childhood if parents and teachers could learn that the "no" of a child mostly has a serious psychological meaning and is not always or mostly an expression of plain nastiness which means that the child does not want to abide by our wishes. These "nos" of children are for the most part results of these emotional strains of overuse and overtiredness. In cases where an actual long-lasting and pronounced defiance attitude develops, one can be sure that a general psychological problem is the reason. And only if we take such defiance seriously and make ourselves aware of the reasons can we help the child and not contribute to educational delinquency and harm.

Behind a defiance stage, a tendency to or an already developed stage of a depression must always be looked for. This depression may come from either of two directions. It can come from outside when the child is forced to overtax his emotions and must encounter too many bad experiences—this would mean

that the problem has a *perceptive* cause. There can, however, also exist as a reason the fact that the child has not the ego strength to digest and to assimilate what it has to experience. In such cases the problem would have a *receptive* cause. Our examples in cases 1, 6, 7, and 10 doubtless encountered too many bad experiences from outside which they were unable to accept, whereas the children in cases 2 and 9 had weak or undeveloped egos unable to digest their experiences. Prevention in most cases is the only right cure, which means that giving in to the restraining desire of the child will remedy the condition in the fastest and best way. Any forceful pressure upon the emotional nature of a preadolescent always creates strong negative depressive elements and aggravates basic problems. This does not mean that we are preaching catering to any and all whims children may have. The sincere eye of a teacher and the loving observation of a parent will be able to differentiate between an emotional conflict and situations where only youthful playfulness is the prevailing factor.

Another factor, and probably the most important one on the emotional level of the preadolescent, is that of the involvement towards further development of adolescent maturity, which, of course, coincides with the emotional maturing. We know that before our children are able to face sex, in this preadolescent period they go through the stage where they align themselves with those of their own sex and do not have any positive dealings with members of the opposite sex, aside from battling group against group. Parents, with an adult view sometimes ironically referred to as the "battle-of-the-sexes" attitude, laugh about this premature negativity of the sexes. From the point of view of juvenile development, this separation of the sexes before the start of adolescence has quite a different meaning. There is no doubt to those with proper insight that eroticism and sex in adolescence is primarily emotional, in all probability the most powerful emotional experience. Preadolescents, in the stage of maturing emotionally but not yet possessing a mature sex personality, are not ready for these emotional experiences. They may be perceptively sensitive for these experiences, but actually do not want them. Therefore, they are most unwilling to go

through with them and so avoid the other sex. Where meetings are unavoidable, they result in emotionally negative responses. This stage is actually the reverse of the later "sex battle," which has a positive basis. The preadolescent attitude is basically negative and leads to very depressive features which may increase to an actual pathological depressive stage. Although we were not able to complete our study on the childhood histories of manic-depressive psychotics, from the cases I have seen and personally studied, I can say that in most of these the negative development involvement of adolescence was shown to be an important factor. We have during the recent period of psychiatric knowledge heard much of the basic difference between neuroses and psychosis and the fact that one could not actually develop into the other because both have different backgrounds. This factor appears strongly in depressive cases and the viewpoint presented here enlightens this theory considerably. All depressional diseases of the preadolescent period are actually neuroses, due to a disbalance of either the perceptivity or the receptivity of the psyche. Adult psychosis is actually a pathology of a total of the psychic structure of the personality which has not existed earlier and which involves those features of adolescent emotionality mentioned above and which we will discuss in somewhat more detail here. When we apply the concept of psychoses to children, the same meaning has no validity. The symptoms are those of adult psychoses but the manifestations are not the same.

Psychologically, adolescence does not only mean ability to experience sexual and erotical sensations due to the corresponding physical maturity of the sex organs; a psychic stage of maturity is also reached, which means a development of *will*. It is one of the deep and amazingly wise laws of nature that the last step in the reproductive capacity of man, the functioning of the sex organs which makes for the survival of this special kind of being, is connected with the final maturing of the psychic functioning of the individual will. All primitive prescientific and religious concepts knew this and gave it expression in ritual ceremonies in which self-decision was in the hands of the youth who could and now had the proper will to perform his function. Our mod-

ern psychology has straggled behind considerably regarding insight into these facts, with the resulting practical and educational as well as mental-hygiene consequences. Will maturity, according to the concept here discussed, comes under the direction of the actual agent of the individuality of the will. It is not only an intellectual ego; it is now a self-willed ego. In the entire sphere of the emotions and feelings, this means that they come under the ability of a definite control of their range in positive and negative experiences, as well as into the definite power of control. Prior to this stage emotions are not under such definite ego control, but at the same time they do not play such an intensive rôle in the total picture of the individual inner experience. Now they can be loaded with all the desired volitive expressions directed against sex as well as anything else. Before, if emotional life became more or less seriously involved into negative permanent experience, the involvement centered around the emotions alone and could not reach beyond the point of neuroticism. After adolescence, however, the root of the entire negative experience has another center, one which almost always involves the total personality; this means that in most cases a psychosis results. It is, as Kraepelin expressed it, an involvement "*des ganzen Gemuetslebens*" (of the total inner life), so far are emotions precipitating. Since there is also a considerable widening and differentiation of all emotional experiences after adolescence, we find, as we mentioned in the introduction, the possibility of the existence of various types of emotional negative involvements—in other words, different types of depressive diseases. These differentiations are apt to appear at the start of adolescence, and I have tried to present cases 6 and 10 in a way to illustrate the appearance of these different depressions. We also have to expect them to appear as part of the pattern of other mental ailments, as we have presented. There is hardly any mental disease that is not affiliated with a depressive and even manic-depressive pattern.

It is rather unfortunate that it is almost the common belief of American youth leaders that milder depressions are almost an expression of adolescence itself and that practically every adolescent suffers from it. This is, of course, going much too far. As

we mentioned before, during the preadolescent period almost every youth goes into the negative stage against the other sex. This is indeed almost natural and appears in a mild form in every youth. Unfortunately, the living conditions in our cities cause a frequent carry-over of this attitude into adolescence itself, and with this a tendency to depressive upset, especially in the direction of the involvement of the emotions in the balance of the maturing sex and erotical nature. If things do not go quite straight, the reactions of the former "natural" negative attitude come forward again, and we are presented with specific adolescent depression in the form youth leaders like to disregard. It is indeed easy to believe that we free our struggling maturing youth by simply disregarding their troubles. Fortunately, responsible youth workers do not feel able to handle the problem in this way. We certainly need much more insight into the mental dynamics of adolescents, of which their emotions are only a part.

It has been established that adolescents have the tendency to use depressions as a kind of escape, but even this tendency is part of the pathogenic picture which we must have under consideration in view of the mass of late teen-agers who sink into severe depressive psychoses. We are far from seeing clearly the preventive means, really sound and effective preventive means. If we study depressions in the adolescent, one element must be taken seriously into consideration—the certain basic tendency underlying depressions in this period. The tendency leans towards the newly matured sex sensitivity, even if the depression may have been caused by completely different experiences, for example, failure in school, or social struggle with family situations, etc. We find that such youth develop sex depressions after a while and that the beginning of the most serious episode is an attempt at masturbational release. Of course, not all masturbation and not all adolescent masturbation has this background, but this pattern can be found in every serious case.

In turning now to the *manic* side of the disease pattern, we must first emphasize again that we are dealing with the overexcitement and overactivity expressions of the emotional life of the child. Nobody in the entire literature devoted to the study of manic-depressive expressions in adults or children has been able

to give a satisfactory explanation regarding the interconnection between these two emotional extremes. There is no doubt that this explanation should fall in the direction of compensatory types as they have been formulated by Kretschmer (127) and C. G. Jung (114). Jung's extrovert and introvert, with both appearing in the mental attitude of the same person (one in the conscious and the other in the subconscious) seem to me to lead nearer to an understanding than the Kretschmer types which have been used excessively in the discussion of the relation of body typology and depressive symptoms. However, although I am pointing to Jung's typology, I do not wish to give the impression that I am using it in the identical way. The nearest key to the understanding of the occurrences of depressive and manic episodes in the same individual in succession seems, to me, to still lie in the parallel healthy attitude of a sedentary tendency, as the desire for physical activity after this healthy contradictory tendency moves into the sphere of the pathological extreme. That an individual should lapse into a period of deep depression and generate a considerable amount of unhealthy dynamic energy with the tendency towards a manic eruption, is almost as "natural" as our compensatory strive after a day's work in the office. Of course, such an explanation is only an approach by proxy and cannot be definite and detailed. But it is a step in the direction in which further study should advance. The most difficult crux of such study must, of course, be the understanding of why manic expression assumes different tendencies and appears in different forms. It has already been emphasized that the most basic difference between juvenile depressions and juvenile manic utterances is that the latter comprise a variety of expressions which actually appear to reduce themselves more and more to a specific routine pattern in manic episodes in advancing and later life. The reverse is observed in depressions, which are almost uniform in early childhood and become more polyform in later stages of life.

Although I do not wish to have my explanation considered as a final answer, from the theoretical position of dynamic psychology which we applied here, these differential manic expressions

seem to me not too difficult to explain. That a small infant who has not developed beyond the stage of using its arms, kicking its legs, and turning its head, uses these few activities to work out dynamic needs and expressions will seem to us quite natural. In observing individuals in manic episodes, one has the feeling that they too do nothing more than what such a baby does, airing themselves according to their motility and action possibilities. Often there are unusual limitations in them, which has led me to assume that they suffer—a great number of them, at least—from some sort of motility infantilism. However, one often finds too that these manic spells are used to express suppressed emotional upset. For example, the boy in case 1 produced this noise spell to annoy the mother; case 2 tried with his foolish actions to take revenge on his environment; a similar tendency existed in case 8, of the boy with the deformed face.

Special attention must, of course, be given here to the speech cases, which I have grouped together for this purpose. Since speech is such a subtle part of early childhood development which later on parallels the intellectual and mental growth of the individual and is almost like a seismographic instrument of reaction upon all our inner experiences, it is no wonder that in many individuals the manic tendency uses speech as its expression. This alone, however, is not a detailed explanation of why such individuals develop stammering or stuttering spells. There is no doubt that a great number of cases of speech deviations have manic tendencies as their background and many could be helped if this could be recognized and treated as such rather than with only mechanical speech therapy. After studying a great number of cases of speech pathology in which the manic background was evident and from which I have selected the three cases presented in the first part of this paper, I have come to the conclusion that I cannot see any connection between the course of the manic episodes and the actual occurrence of the speech disturbances. I do not feel able to establish a rule regarding the reason why the speech disturbances appear immediately at the start of the episode or at its climax. These occurrences seem to be individualized in each condition.

However, aside from our knowledge that speech, or to be

more specific, the expression of our inner experiences and their communication to other human beings, is in its development very strongly tied up with our inner psychological or mental development, we know that the actual full maturity of verbal expression coincides with the ego and intellectual maturation at the age of three. If anyone, following in the steps of Mauthner (138, 139) would work out psychologically the mental birth and growth of speech ability in the infant and preschool child, it would be found that the child grows from the use of single-word language, mainly nouns, to the full logical ability of use of language at the time of ego maturity. Certain steps, once described by me in a paper published in the Lettish language only, can be observed which give a clear indication to what extent speech is actually an agent of the human mind and its development. We see later on the coordination between language and inner maturation in the mutation or change of voice which appear during the adolescent development and which, in my opinion, is not less a "secondary sex symptom" than that one of the will maturation. All of these factors point in the direction of the intimate tie-up of speech with psychic development and also to a more intimate relationship between emotional expression in youth and the use of language. It is, therefore, understandable that in certain cases, where such development is somehow a weak point in the child's make-up, emotional disturbances will be expressed and carried over into speech pathology. Of course, today it is being emphasized that many stammering and stuttering cases have psychopathological or emotional background, but attention is hardly ever given to the fact that in many cases these speech pathologies are the expressions of manic tendencies. This is definitely so when these speech pathologies occur only in certain periods or intervals. These intervals may be a question of hours, but they can also be a question of weeks. Of course, a depressive counterpart of the psychological life must also be observable, but I have rarely seen a person with a more or less severe speech impairment who did not suffer from some kind of depression. I do not wish to give the impression, however, that I believe all speech pathologies are of manic-depressive origin, for they certainly are not.

In reviewing more detailed the three speech cases presented here, it seems to me that the first case (case 4), that of the little girl who had difficulty in starting to make use of human speech communication, is in some respects a characteristic case of this pathology in early childhood. Many cases of mutism in later stages of childhood have been noted, but they are not of this specific manic-depressive character. The same can be applied to such rare mutism cases found among adult psychotics, which can be of schizophrenic, hysteric, or melancholic background. But nowhere can be found such an intimate tie-up of the language pathology with the entire sickness of the individual as that which exists in this stage of childhood, when mental and language development is more closely coordinated than it is even in the preadolescent or the adolescent period. In this case, working on the inner growth of the entire personality meant working on the language ability. The entire fate of this child centered around her language problem, although later mutism was only an expression of resignation or blocking. There is no doubt that the child herself had an awareness of the language problem all the time, but her working herself toward a solution resulted in manic episodes, a specific trait of this type.

However, the little boy a year older described in case 5, represents quite a different aspect of the entire problem. He already was able to speak and was actually far ahead of his age level in mentality and even in his speech development. His speech pathology appeared at the climax of a manic tantrum outlet. The emotional upset in this tantrum was so strong that his speech ability could not follow and parallel it, and the disturbances developed were so strong that havoc was created in the speech mechanism, much like the influence of a storm on a telephone wire. He himself had difficulty in restoring it. We know that adults too may become disturbed in their speech ability due to serious emotional experiences, as evidenced by the colloquial expression of "standing there with open mouth," as well as the old English expression that "fright took spit and word out of his mouth." Only the deep tie between emotional life and language, characteristic of the second half of the first ten years of life, is able to produce such kind of severe disturbance as was observed

in this boy. This case was selected because the stammer-stutter episodes came but rarely and were strongly associated with the manic spell. The last of the three cases (case 6) dealt with a preadolescent who under normal conditions probably would already have reached physical maturity, but who showed all symptoms of physical and mental retardedness. Her stammer-stuttering ailment had already developed into a full-fledged routine pattern. She used it as a defense when she had to face new, and for her, embarrassing events, and also as an easy form of expression for her manic spells. There is, however, no doubt in my mind that there is a deep tie between her depressive-manic illness and speech pathology, and I am sure the stammering is a manifestation of the condition.

In turning to the four cases dealing with adolescents, we find the picture considerably changed in regard to the total psychological background of the manic-depressive abnormalities. All these youngsters reached a high level of emotional maturity and were quite aware of their difficulties. Since will maturity was the main issue here, they were all bothered and worried about the problem of controlling their emotional difficulties. This related to the general depressive condition as well as to the manic spell, in which they experienced a still worse lack of control; therefore the greatest desperation centered around the spell rather than the depression. However, since the entire emotional sphere of experience has widened in this stage, as we mentioned before, a greater variety in the depressive experiences than in earlier stages, and since "living one's life" has become a matter of routines and forms, we observe the manic utterances carried into such routine forms. They are such severe and painful experiences that the desire is natural to have them expressed in the easiest possible way, and this is done in automatic routine attitudes which later on become tragic mannerisms and purely automatic outlets, as we have observed in adult manic psychotics.

In case 7, the entire illness had not yet taken too severe a form because of the healthy physical background. The boy only experienced the manic attack as "something which started to get him." Of course he was highly worried, but since the outlet had

not yet assumed any kind of automatic pattern, it was rather easy to cure him. One point, however, which seems to me important to emphasize is the connection between sexual pressure and this manic spell. We know the tragic form in which this symptom appears in many of our adult insane who lose mental controls. Here it appears in its earliest form. This case history should be thoughtfully considered by many parents and educators in relation to the thousands upon thousands of similar cases of so-called "masturbational bad habits," which can be cured properly only if the emotional disturbance background is realized and accepted as the actual case and the only sound basis of cure.

In case 8, we see the manic attitude more advanced into a definite negative pattern. We deal here with a person coming from a social background which makes understandable his more vital and actually more violent expression in his manic spell. There is no doubt that the unusually good personal background saved this youth from slipping into an actual delinquent psychopathological pattern. Feeling that he could not control his manic desire to use the piece of broken glass on someone, he was relieved when I asked for permission to keep it. Again, the specific character of the manic spell is in the feeling of lack of will control. Also easily recognizable is the greater extent and variety of emotional expression, especially when their pathological character was observed by the boy. Of course, in most such cases, one with a sharpened eye can observe that often simple rather than such severe manic patterns tending toward violence are used. This particular case was selected for presentation here because of our desire to make the entire picture as impressive as possible.

In case 9, the actual manic expression is carried over to a phobic outlet for which, without any doubt, there existed a great tendency in the entire makeup of this girl. She also exhibited other mannerisms, like trying to hold onto the mother, which she probably had done even as a small child. Nevertheless, these manic attacks were of such great violence that there was not any tendency to express them in a specific way. Indeed, from observance of the entire pathological background of the girl, there seems to be good reason to believe that she expressed the manic

spells in forms which were actually latent in her from former and other pathological expressions. It may be important to observe that the real manic-depressive side of her very complex pathological nature came clearly forward only after major symptoms of her other pathologies had subsided or had fallen into the background. This does not mean that these manic-depressive tendencies did not exist before; they just did not have much of a chance to become predominant. However, I do not feel justified in giving vent to thoughts and vague speculations in regard to the deep relationship of the various pathological strains in this girl; the only definite conclusion I can reach lies in the relationship of the manic spell with the occurrences of her irregular menses. It is my hope that similar cases, if reported, may offer, by means of comparative study, some insight into these pathological connections.

The manic spell in the last, case 10, is the strangest of all. The first point to be taken into consideration is the fact that an excitement starting point for the direction of manic spell always existed in this boy. Then the boy's propensities were turned away from the really desired direction. This is evidence of will-pathology, in line with our emphasis that most adolescent manic spells are of such character. From a pathological viewpoint, it seems to me that the schizophrenic trend got the upper hand and directed the dynamic of the manic spell. In reality this pattern of action is known to psychopathologists as being more schizophrenic. It has even become fascinating to one of the greatest psychological writers. The famous philosopher, Fr. Th. Vischer, has made it the subject of his novel, *Auch Einer* (*Also One*) (178), where he calls it "*die Tuecke des Objekts*" (the malice of the object); the hero always acts against his own aim, or, as he formulates it, "the wrong things always get into his way." However, what may even be found in the frame of Freud's psychopathology of every day, becomes in our case the element of a serious pathology, due to the entire setting and circumstances governing its appearance. Of course, the entire pathological picture in this case is so complicated that it seems almost impossible to unravel it and label it according to usual somatic patterns. I felt, however, that this case should be re-

ported since it is the only one which ever became known to me where the manic spell took this form.

I hope that what I have here reported will help to again restore the manic-depressive soma into the field of child psychiatry and abnormal child psychology.

VI

POSTENCEPHALITIS

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INTRODUCTION

POSTENCEPHALITIS APPEARS in such a variety of forms that it is difficult to find a typical case which can be considered a somatic common denominator for any great number of cases (142). In addition to the various definite types, we are confronted with many atypical appearances which cannot be combined into any group. I have therefore chosen for description a case which shows a number of symptomatic features typical of the greatest number of cases. The patient, Roy, was seven years old at the time of study.

FAMILY HISTORY

Insanity is reported on the paternal side; the father's half-sister and an aunt died in a mental institution. Linguistic deficiencies on this side are also reported. The mother states that she comes from a perfectly healthy family, but a distant cousin has a child who is mentally deficient.

Roy's father is a businessman. According to his wife, his youth was not a happy one since he was brought up by an unkind step-mother. He is a restless, neurotic person, but with no specific pathogenic predominant traits. He has a very slight speech defect, a stammer, which, however, is noticeable only when he is excited. Roy's mother was a teacher who married when she was twenty-six and her husband was thirty. Her youth was normal and she had the usual children's diseases. She continued to teach after marriage and for two years (with a year and a half ma-

ternity leave) after the child was born. Three years after his birth she developed "back trouble" following a fall. This resulted in a loss of bladder and bowel control for a short time, and is still painful. The diagnosis, not confirmed, was a dislocated disk. However, there were doubtless spinal injuries. When Roy was five years old and his handicap was definitely established, the mother decided to have another child. This child was normally born and is normal to date. The mother is now very neurotic. Through the years she has accused herself of neglecting Roy when he was an infant by continuing to teach and thereby causing his stammer. She cannot overcome the shame of having a handicapped child. Together with this, the task of keeping house for two children has forced her to take long leaves of absence from teaching, but she cannot make up her mind to resign. She feels mentally superior to her husband and fears that she will lose this superiority if she gives up teaching. This attitude seems to be very important for Roy's development.

PERSONAL HISTORY

Roy was born in the fourth year of the marriage. His birth was planned, and the pregnancy was delayed for a year because of the mother's appendectomy. The mother says that her pregnancy was the happiest time of her life. The birth was a normal "dry" birth after twenty-seven hours of difficult labor. The infant was breast-fed for only a few days and then, because of an inadequate supply of milk, he was put on formula feeding.

According to his mother, Roy seems to have developed normally during the period of infancy. The basic achievements—sitting, standing, walking, and "making sounds"—were accomplished at the usual time, and he seemed to be a good-tempered, gay, and intelligent child. At the age of fourteen months he had a "strep throat" with a high fever, and a similar period of fever occurred when he was two years and ten months old. This was accompanied by severe pains in one ear which a physician diagnosed as an inflamed ear. This lasted for about three days, but shortly afterward his mother observed long periods of restlessness and sleeplessness. A short time after this attack there were definite signs of regression. He had been a slow speaker, but he

now became almost mute. His physical movements also became slower. He "seemed to be afraid" of many things. Although his physical growth was normal, his features were increasingly those of a backward or defective child. He developed anger spells when forced to do certain things, and when he was not understood, these took the form of mild tantrums. The ambitious mother attempted to teach him to speak by force. He invented a language almost completely composed of vowels, the reason for which we shall discuss later. The mother has consulted almost every neurologist, psychiatrist, and speech therapist in the city in which the family resides.

When Roy was five years old, an examination in a neurological institute showed a lack of coordination between the motor action of the hands and feet caused by a defect of undetermined origin. The physical speech organization was normal. A certain pattern of behavior disorder characterized by restlessness and irritability was emphasized.

A well-known psychiatrist, consulted when Roy was about six, noted a slight delay in the ossification centers shown by X-ray. An electroencephalogram taken at the same time did not give definite results, but left open the possibility of "some disturbances which are located subhemispherically and have not affected the cortical potentials to a recognizable degree." Other physical and neurological examinations at that time gave no further information. Roy proved to be a child of a severely retarded type, incapable of speaking in the usual way, although the mother applied to this task all her capabilities as a trained teacher.

When presented for scholastic examination and forced to undergo a conventional battery of tests, he scored an I.Q. below 70, with slight variation of the quality in other tests. Since these results are not essential to the case, we shall not give them in detail.

FINDINGS OF DETAILED EXAMINATION

Roy was brought to us when he was slightly over seven years old. He was a pale youngster with somewhat heavy features. He seemed to be very fearful and hesitated over every action, but he

observed his environment carefully in order to be aware of everything that happened. He responded to loud hand clapping with a defensive action of his arms. He frequently made a momentary movement with his head which did not seem to have the reflex character of a tic but was rather a reactive movement caused by some kind of internal irritation.

Physical examination showed no abnormality of the speech organs. The nervous system seemed at first to be relatively normal. However, all his reactions were somewhat slow, and there was no Babinski. The first definite symptoms appeared in tests of coordination. When he was made to walk and swing his arms, there was a much slower movement in the right arm. Both feet had a tendency to turn in, the left much more than the right. There was also a more pronounced and frequent twitching in the left eye than in the right.

The clearest indication of defect, however, appeared with my "perseverance test," which is especially valuable in cases of mild or obscure encephalitis. When he stretched out both arms, the right arm sank much faster than the left. When he was placed with raised arms against a wall, the right arm seemed shorter—it was not by actual measurement—and was withdrawn or lowered much sooner than the left. When given a crayon to make pictures, Roy changed the crayon every six or seven seconds, and later even more frequently. In attempting to stand on one leg, he was unable to do so on the left for longer than five seconds; on the right leg he was able to stand for ten to twelve seconds or even longer. I started a playful fight with him, and when he was considerably exhausted and placed on a day bed to relax, the following symptoms appeared: The inside of his hands turned outward, and the elbows were pressed away in an effort to shorten the arms. There were almost constant irritative movements of the head. The feet did not show more than the usual turning in of the toes. His face had an expression of extreme discomfort, and when asked what was wrong he answered in his vowel language that he had "pains all over."

In regard to his unusual language manifestations, the examination made it clear that the impact resulted from painful oversensitiveness of the articulation mechanism which produces the

consonants. The more peripheral consonants like *l* and *k*, which require greater effort, were harder for him to pronounce than those with a more central location. The most important fact was that he was really able to produce any basic speech combination if he was forced to do so with great effort. Doubtless a neurologically determined pain factor was involved. This impelled him to "short-cut" speaking as far as possible, since any effort to use his speech mechanism was painful.

Examination of Roy's intellectual functions revealed a tendency toward overcompensation which is common in this type of handicapped child and which cannot be evaluated with intelligence tests prepared for normal individuals. He showed a superior level of observation and a similar level of memory. During later visits he recalled every detail of the office or of books he had once seen. There was no doubt that he had had normal intelligence which had been retarded by disease factors affecting his nervous system.

To complete our examination, an endocrinological check-up was made. This showed a slight and easily treated thyroid deficiency. Pituitary function was apparently normal.

DIAGNOSIS

There could be no doubt that this was a case of postencephalitis affecting a part of the nervous system. The infection had doubtless occurred during one of the two fever episodes reported in early childhood, one at the age of fourteen months and the second at two years and ten months. It was probably during the second attack, which was accompanied by the middle ear infection, a frequent cause of encephalitis, that the infection occurred. However, the fact that at the time of the second attack Roy was old enough to designate the source of the pain does not entirely disprove the possibility that the infection occurred during the first episode.

We learned from our examination that the most seriously damaged parts of the child's nervous system were the centers for language. Curiously enough, there were no signs that his hearing had been affected. He liked to hum melodies and did it well. He

had also been taught by his mother to play children's tunes on the piano with one finger.

Also severely affected were the centers which control the movements of the arms. The lack of coordination and the tendency of the arms to shorten are the symptoms most specific for encephalitis. This case is of special interest since it is not an arrested case of encephalitis, but one in which the inflammatory process has been active over a long period and was still active when the patient came to our attention. The pattern of this condition is completely different from that of a neuritis. Because the infection smoldered for such a long time, we prefer to call this form *smoldering encephalitis*. It has not often been observed, but it is especially interesting, both for the study of encephalitis itself and for the possibilities and processes of treatment. The extent of actual damage to the nervous system and the probability of cure in such a case can be determined only after a long treatment has been attempted. During the fourteen months that Roy was treated, astonishing progress toward a cure has been made.

TREATMENT

The treatment was divided into three parts. The first was the task of modifying his environment, especially his family. The second was an attempt to cure the actual smoldering infection and to arrest the active process. The third was the reeducation of the child in regard to his abnormal language and his adjustment to a general educational process.

A committee composed of an endocrinologist, a neuropsychiatrist, and a clinical psychologist was formed to undertake the task. The major part of the educational work was left to the mother under the direction of the clinical psychologist.

Therapy with the family was necessary because the parents had completely unacceptable attitudes toward the child's needs. The mother's adjustment was particularly complicated, as she was torn between her wish to train Roy according to her knowledge and ability as a teacher of normal children and her realization that he was a defective child. She had to be given a different educational philosophy. She received information on and train-

ing in the educational task to be faced. After a dozen sessions she proved to be fairly well adjusted to this task. She has successfully undertaken training the boy in remedial language.

Physicians attempted to heal the affected parts of the nervous system by intravenous protein given three times a week during the first ten months, and later in reduced quantity. The results will be reported below.

The chief object of the reeducational program was the language training. This could not be started until the actual inflammation was reduced. The educational measures were carefully adjusted to changes in the child's physical condition. Certain short poems, partly drawn from the literature on remedial speech, were prepared and used by the mother. Great emphasis had to be given to eliminating fear in Roy, as well as to strengthening his ego, which showed great weakness. This was done through the medium of play therapy at the clinical psychologist's office. The educational adjustment of the boy was equally important. After a certain point in language reconstruction had been reached, he was enrolled in a small private school for retarded children, where he could receive the necessary amount of attention. Further measures were applied to allow him to develop a sound relationship to other children.

THE THERAPEUTIC PROCESS

During the first few weeks Roy received physical treatment only. His mother was asked not to make any attempt to correct his speech or to influence his somewhat trying behavior. This was considered necessary in order to enable us to observe the influence of the injection treatment. During the first two weeks nothing special occurred; but in the third week a slight rash developed, and two weeks later Roy had a severe attack of measles, his first childhood disease. When he recovered from this attack, his entire physical make-up had changed considerably. A coordination test showed that he was much more secure on his legs, but his arms were not much improved. His expression showed less pain when he was requested to speak certain words that were difficult for him.

It was now considered the right moment to start his linguistic

reeducation. As he had been fond of listening to his mother's reading, rhymes and short poems were taught to him. These were used as frequent exercises. He accepted this treatment very well, and in a month considerable improvement was evident. Roy was seen regularly by the clinical psychologist, who administered emotional treatment. In connection with the language exercises regular tests were made. It is interesting to note that the improvement proceeded on a scale in proportion to the difficulties of using the articulatory mechanism. Exercises composed of words with the more easily pronounced central consonants were soon executed without difficulty. There was no doubt that the injection treatment had produced some improvement.

After half a year of treatment along these lines, school was considered. Since there was no chance of placing the boy in a public school, a small private school designed for backward children was selected. His progress was amazing.

As the author has mentioned before, he does not consider intelligence tests for normal children to be of any factual value in cases like this.

The therapeutic process encountered its greatest difficulty in regard to overcoming the severe fear pattern in which a combination of phobic elements was rooted. This fear pattern is obviously closely connected with the physical handicap and it cannot be eliminated before the physical factors have been completely cured or arrested.

Judging by his previous progress, Roy may be cured of the smoldering disease in about a year, and it may be another year before he reaches the maximum intellectual and social adjustment which he is capable of attaining.

VII

THE MIGNON NEUROSIS

*Kennst du das Land, wo die Citronen bluehn,
Im dunklen Laub die Gold-Orangen gluehen,
Ein sanfter Wind vom blauen Himmel weht,
Die Myrte still und hoch der Lorbeer steht?
Kennst du es wohl? Dahin, dahin,
Moecht ich mit dir, oh mein Geliebter, ziehn*
J. W. VON GOETHE

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IN THE WHOLE rather neglected field of abnormal child psychology, the problem of abnormalities of mental growth appears to be the most neglected. This does not surprise those who realize how slowly and how recently we have gained insight into the actual forces behind this growth and the various stages of mental development which we now differentiate (125, 134). We have also learned that certain psychopathologies may be connected with given ages. Up till now we have, however, been completely lacking in any insight into the problems of the total growth process and possible mental deviations connected with it.

Before we present our basic views on the pathology of mental growth as a contribution to a much-neglected problem, we must answer that large group of professional workers who will consider us ignorant of the vast amount of effort which has been devoted to what they consider the major type of this growth deviation, mental retardation (10, 34, 95). I do not deny that retardation belongs in the field of pathological development as a specific type of growth pathology. However, the present views on

mental retardation are not all that I wish to consider. Today when we speak of retardation, we are not concerned with the actual growth process but rather with a relationship to an educational or intellectual school level and the ability to adjust to environmentally determined norms. In other words, retardation is measured in relation to the environmental factors involved. We have not yet gained adequate insight into the dynamic factors involved in the pathology of the actual growth process because we have, unfortunately, set our sights in the wrong direction. (I shall deal with this problem in the chapter on "Incorrect Diagnoses of Feeble-mindedness.") I should like to avoid the mistake made by those interested in the retarded child, not by correcting their approach but rather by approaching this same problem from a different aspect: that of the too rapidly growing child (24, 101, 174-176).

When I talk about a too rapidly advancing child, I do not necessarily mean a superior child or prodigy. There are many interpretations of what a rapidly developing child can be. Rather, I wish to present here a pathology of growing up which I consider to be one of the simplest and at the same time one of the most significant. I have selected for the growth pathology the name Mignon neurosis, referring to the original Mignon story as told by Goethe in his novel *Wilhelm Meister*. Let us present here what seems to be one of the most characteristic cases of this pathology.

Case—

Ingrid is the eight-and-a-half-year-old daughter of two American-born parents. The father, of Swedish descent, is a painter. The mother, of Italian descent, was a student of dramatic art. They married when barely twenty after knowing one another only a few months. The marriage was primarily the result of the pressure of the young girl who feared losing this attractive lover if she did not make things permanent. Ingrid was born after two years of what seemed to be a happy marriage. When Ingrid was eighteen months old, her father was called into the service. He gave up his studio, and the mother and the little girl moved into the maternal family home where the mother's parents and

six adult siblings lived. Ingrid was the only child in this crowd of adults and she complained bitterly about this when brought to our clinic. The reason Ingrid was brought to the clinic was that she had become truant, having decided not to go to school. The mother had tried everything to get her to accept public school. However, the school asked that she be removed and that she receive guidance. Ingrid is an unusually attractive youngster who is almost too neatly dressed and too well-behaved. After spending about five minutes in my office, she wished to sit on my lap and began a campaign of her own which resembled that of a mature flirtatious woman. She indicated that I was "such a nice man" that she "likes me very much" and that she knows I must get her to go to school but that she hopes I will listen to her and not force her to do so. She states that she is taking tap-dancing lessons, that she will become an actress, and that one does not need to know all they teach you in a school like that. Her favorite topic is embarked on when she asks me whether I am married, and says that she is sorry to hear that I am because she likes me so much and if I had waited a few years she would love to marry me. In her own mind she has completely worked out everything in respect to bridal preparations, and her infantile imagination has dealt with marriage. She has offered many times to draw her wedding dress which she will wear and will almost always bring to the clinic a drawing of herself in the planned bridal costume. There has been no masturbation and all her imagination about marriage involved no sex image of any kind. Actually she had no understanding of the sexual process. Her I.Q., as far as could be established, was at least 110. However, her ability in basic skills was hardly above that of first grade. She simply did not want to learn or assimilate any knowledge beyond the actual adult adjustment to life. By temperament she was a most extroverted child. She constantly watched her environment and tried to please everyone. She was unusually quick in learning to speak English and had a very slight accent but an unusually rich vocabulary. Her basic social attitude was that she preferred to be with adults and never wanted to play with other children. The only time she wished to have contact with school children was when she was promised that she would be allowed to perform

a tap dance before the school assembly if she agreed to attend school. This, however, was not sufficient incentive to get her back into the classroom.

There is no doubt that the main factors in the development of this child's attitude were the environment in which she had to live. She was constantly with adults, directed by their concepts and attitudes towards life, and she had to compete with them. She complained to me about the noisiness of these Italian relatives and how she had to rush to the dinner table since everyone was concerned only about himself and there was often nothing left for her to eat. On such occasions she and her mother had to eat bread and milk as their evening meal. She was also indoctrinated with erotic and socially superficial ways of thinking about life which reflected that of the young adults about her. All this was expressed in her orientation to life and her desire for adjustment to what she considered the adult way of living.

If she had been a child with a normal developmental attitude, normal intellectual curiosity, and adequate desires for social adjustment on her own level, she would have to a certain extent withdrawn from these adults and would have wished to learn to read and write and to understand the world about her. Instead, there was this definitely neurotic pattern of attempting to act like a grown-up while still definitely a child. One often had the feeling that she knew that she was putting on an act which was related to an entire life pattern.

During the years of my practice, I have seen quite a number of such little Mignons. They all have the same features. None of them wanted to grow up in accordance with the natural course of development, but rather they wanted to play at being grown up: the five-year-old wants to play at being the newly-married twenty-year-old. If asked to draw pictures they all produced either bridal dresses or themselves in the bridal scene. They all wanted to associate with adults, preferably males, and hated being with children of their own age. They all dreamed of having some kind of glamorous profession, such as being an actress or dancer. They were all extremely difficult to treat. They came from various types of homes and only a few grew up in an environment like that of Ingrid.

This Mignon type is not confined to girls alone. I have found boys of the same type though not in the same number. While the girls' fantasies of adult life deal mainly with marriage, the boys have fantasies about some kind of glamorous career such as flying, auto racing, exploring, traveling, or the like. These dreams of a career are impractical and unrealistic. For example, they do not wish to be commercial flyers or automobile mechanics, nor do they really want to know about the countries they hope to explore or travel in. They do not associate with people who might aid them in gaining information about the things they profess to be interested in, as for example, such as pilots or garage mechanics. They are all equally disinterested in schoolwork and a wider social education. They, too, are unwilling to associate with their age group. They try to mingle with older boys whom they attempt to impress with their fantastic stories. They hate girls and have no leaning to older women on the *materna* basis. I have found an astonishingly high percentage of this type among the boys who become victims of sexual perverts. As a group they have no other signs of a particularly premature sexual development.

In comparing the female and male types of this Mignon neurosis, one will find natural differences which correspond to the pattern of development of young people in our culture. The maternal rôle is impressed upon our girls by play with dolls and the mimicry of household activities. Boys get their direction towards professional attitudes in the same way in their play patterns and from the toys we give them. Most of these are on the somewhat adventurous side, e.g., the cowboy, Indian, soldier, and police outfits with which we provide them. However, the Mignon types of both sexes do not simulate adult activities through play patterns as do healthy children. Ingrid would not touch a doll since "that is for babies or little girls," boys of this type will not play with such "silly stuff." They all want the real thing, even if it is only in fantasy.

The Mignon neurosis represents a one-sided developmental pattern in which the child wants to grow up faster than he can, in which he lives in a fantasy of being already grown-up and refusing the ordinary, normal developmental patterns and the ed-

ucation which is part of them. They are neither physically nor mentally advanced to the point where they actually wish to take on the adult rôle in its full meaning, but with amazing persistence continue to play the rôle in fantasy. If not given the proper kind of therapy, they usually—so far as I have been able to determine—end in incurable pathological states. This is particularly true of the boys. Some of the girls can find someone to marry and thus may go on with the fantasy within the framework of reality. I have never been able to study the development of such a case. Psychopathologically, the Mignon neurosis may be designated as a paranoid pattern related to a schizoid background which may sometimes actually develop into a case of juvenile schizophrenia. Some present-day psychiatrists may wish to label it as a behavior disorder. Others may accept our classification of it as a developmental neurosis.

Therapeutically, this neurosis is unusually difficult to deal with because it demands intensive treatment and reeducation over a considerable period of time. There is no one specific technique of therapy which may be advised. Therapy for these children is always a highly individualized matter. In some instances simple persuasion about the need to know the school subject may work. In other cases playing up to the fantasy may help to get the child back into the classroom environment. In all cases the therapeutic task requires empathy and the willingness to work out methods suited to the individual. In order to place this presentation of the Mignon neurosis in its correct background, it is now necessary to discuss the problems of deviations of development in general and some of the other types we encounter. In the Mignon neurosis, the pathological picture is one of a disorder of the child's mind; in some respects functions are abnormally advanced while others are abnormally retarded. This retardation is due to the desire for a more rapid development, and it is this fact which puts it within the framework of psychopathic advancement. It is important to recognize that the actual abilities remain intact. In the whole area of precocious development, the Mignon neurosis represents the greatest degree of derangement.

Less deranged children who are still primarily of this type are to be found among the prodigies. We have in psychological liter-

ature a number of concepts which aim at the understanding of the superior child or prodigy (90). I have found that the simple and most useful is the concept of the total personality and of the psyche as a dynamic unit as in the conception of C. G. Jung (113), which allows us to see various functions developing side by side and at the same time including relationships to others which are either advancing or retreating.

In accordance with this concept we would expect that when a child has precocious mental development, if he is still within the range of the normal, there would be a more rapid development in all the other major functions of the child. This, however, is purely hypothetical. Even if we assume only a limited advancement, it is rather rare that a child is unusually able in everything; in science, in the arts, in social adjustment and sports. The universal genius occurs seldom; and even when it does, careful examination will show that all of the potentialities are not at the same level.

Because of the multiplicity of human activities, it is almost impossible to expect parallel development in even the major abilities. It is educationally unfeasible for a child to have the time to receive training in the various fields of music, art, and the many sciences all at the same time. We do, however, have pupils who obtain high marks in almost every subject in which they receive instruction. These youngsters are often also extremely competent in sports, too. In these instances there is a potentiality for rapid development in whatever area we reach. However, these children are not at all like the ones whom we consider really extraordinary and who have the potentialities of the prodigy. The abilities which we associate with genius usually occur singly or at most in combinations of one or two. In order to evaluate such unusual abilities in relation to their rôle in the total personality, the concept of the psyche as a closed dynamic system seems more valuable than any other. The occurrence of genius ability and its development necessarily means a derangement of the personality even if it is to be considered a positive one. The prodigy and those responsible for him often tend to devote most of their time to the further development of a special ability and to neglect other aspects of education. Educators who are con-

cerned with the total individual always try to exert their influence in the direction of a well-rounded education, as well as allowing for training in the special ability.

In general, it is not so much the special ability which tends to produce the mental abnormality of the prodigy but rather the increased sensitivity which is not limited to the field of special ability but which pervades the total personality. I have compared genius with tall trees which in a storm are exposed to stronger movement and wind pressure than are the smaller trees and shrubs nearer the ground (71). Heightened sensitivity increases the demands on the ability to withstand tension and pressure, which requires greater strength of the total psychic and mental constitution and particularly of the ego. We all are familiar with the oversensitivity, irritability, nervousness, and peculiarities of the great musicians, poets, actors, and scientists. The special abilities which may continue to increase in time are paired in the rest of their personalities with abnormal features which doubtless have been created by them. This is the same pattern as in the Mignon neurosis. We know that such abnormal features can in such intense individuals lead to actual mental illness. History is full of such cases like that of Van Gogh and Jakobson, Hoelderlin and Nietzsche. These are the most extreme cases where the intensity of development becomes responsible for the end of life. There are many of those who complete their work early and die young as, for example, Novalis and Mozart.

Charlotte Buehler in her book, *The Human Course of Life* (30), thoroughly studied the problem of the too rapidly and also of the more slowly developing great man. Examples of artists who reached their greatest maturity at a later age are César Franck and Joseph Conrad. The extreme opposite of this is the mentally retarded child.

For some individuals slower developmental patterns are as natural for them as are rapid ones for others. We know much more about the problems of the education of the retarded than we know about the education of the rapidly developing child. We know very little, however, about the factors of retardation itself, since we have been preoccupied with the goal of achievement and not with the causes of the inability to achieve. It seems as

though the structure of our Western civilization and its urban patterns have vastly influenced the retarding of individual development. The chapter on pseudo-feeble-mindedness does, I hope, make this evident. Many years ago one of the most influential German educators (46) said that actually each of us is somehow a Kaspar Hauser hemmed in by conditions which hinder our natural development. Even if we consider this statement as somewhat radical, it may be in part true when we examine what our schools do to our city children (29). Those of us who have been working in child-guidance clinics know that more than half of the complaints about these children are related to environmental and social factors. There are, of course, individual reasons for retardation and many which may be attributed to the combination of both areas. In almost every case of developmental retardation we will be able to find traces of both. As to the individual factors causing developmental retardation, there are, of course, the large group of organically caused defects due to prenatal factors or birth injuries, the high percentage of postencephalitics and those with otherwise defective constitutions. There are also a considerable number whose retardation is actually psychic and mental. If we wish to solve the problem of retardation correctly we must see that even if a physical, organic, or neurotic defect seems to be the basic cause, the method of therapy should include influence upon the psychic and mental spheres. If we evaluate all retardation as physical defect only, as has been done widely, we remove the major premise for therapy. We ought to re-evaluate this problem, as we evaluated the pathological conditions of too rapid development in the Mignon neurosis, and consider retardation primarily and therapeutically as a neurosis. This gives us an approach to therapy. As we stated above, the mistake in evaluating psychological retardation lies in the fact that it has been considered only as an intellectual defect. It is often not the intellectual part of the psyche but the emotions and the factors of will and motility which are involved and which may even be the focus for the retardation. Determining the problem of the course of therapy with this viewpoint has frequently made possible considerable progress in learning and social adjustment. It is important to understand that retardation is a

derangement of the total of the dynamically conceived psyche, a factor which we so often overlook in our approach to the total pathological state. Conceived of as neurosis, retardation can then easily be understood as a derangement of the natural state; and therefore, in a poorly equipped psyche, we see that a desire may even exist for compensation and adjustment, often to rather primitive ways of living (150). Those of us who have worked with badly deranged, mentally defective and psychotic children who can only live in institutional situations have frequently been astonished by the way in which these children compensate for higher ability with what may be called by some more strongly developed animal instincts. I have frequently observed that these children could—apparently through an overdevelopment of the sense of smell—tell in which pocket I had candy. This approach will also aid us in understanding the idiot savant (62). The idiot savant may be considered as retarded in areas other than the perceptive functions. There is an overdevelopment of perceptivity to compensate for the retardation, but at the same time there is no coordination of this often highly precise ability to perceive a selected aspect of the environment. The idiot savant soma is parallel to the Mignon neurosis; certain functions are neglected and retarded while others advance unduly. Here the development is neurotically centered in the perceptive sphere without, unfortunately, really compensating for the retardedness of the rest of the psyche. In relating the idiot savant to the Mignon neurosis we complete the total picture of developmental disorders in childhood.

Part Two

**DIAGNOSTIC AND
THERAPEUTIC PROCEDURES**

VIII

CHILD ART AS DIAGNOSTIC MEANS

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ANYONE AT ALL familiar with diagnosing the mentally diseased knows how difficult it is to receive satisfactory and clear information from such patients. It is considered as itself a pathologic symptom that the mentally unbalanced or diseased individual is less able than a normal one to recognize, describe, or have real objective understanding of his inner life and his circumstances.

Anyone, moreover, having to deal with his own or other children, knows that even the most intelligent child is, in this respect, in the same position as the mentally abnormal adult. Also, the normal child has, not only as a baby, but until the middle of the second decade, considerable difficulty in recognizing and describing even the normal and most simple events of his mental life. Although a child of ten is able to form a clear impression of facts of the world around him and his wider environment, it is usually not until after adolescence that a youngster is mature enough to be able to express clearly in words, feelings, and affective processes—something which many adults are not able to do.

A tragic situation arises when both factors described are combined, as in cases of mentally diseased children. As juveniles they have a natural inability to express themselves, and as psychopaths they are still further restricted. All who have to do with juvenile neurotics know their tragic helplessness, which is distressing, for we are almost completely unable to learn from them the necessary information needed to help them. If one is not willing to accept without reservation certain dogmatic theories of psychoanalysis, with its rather doubtful diagnosis (74),

one is unfortunately forced to confess the lack in many cases of any simple and undogmatic diagnostic method for child psychiatry. This is especially weighty because child psychiatry needs, even more than adult, clear somatic pictures.

About fifteen years ago, when in Europe a great interest in child art was suddenly rising, I saw for the first time the artistic products of juvenile neurotics. I was already seriously occupied with the question as to whether such documents could be used for diagnostic purposes. At that time I was occupied with a study of border-line problems between language and the fine arts as means of human expression. I used, as illustration, the case of the well-known Swedish dramatist, August Strindberg. This extraordinarily able artist made use of color and brush during periods in which he felt himself, because of psychic depression, unable to express himself by words (98). He tried to "say" his certain inexpressible mental experiences in the pictorial way. In a treatise called "Strindberg as Painter" I discussed this as a phenomenon of unique interest from a psychological and psychiatric viewpoint. Such studies developed in me the tendency to consider artistic products of juvenile neurotics from the same viewpoint and to suppose these products might be created out of similar emotional states. I saw things painted, which the children would never have been able to express in words, even had they been fully conscious of them. Already the question was rising in my mind as to whether it might not be possible that both healthy and diseased children have a tendency to express mental states which they cannot put into words in a pictorial way. But, however much interested, I was unable to complete any research necessary to answer this question (81, 87).

Shortly after my arrival in America I quite unexpectedly came to occupy myself with this problem again. The suggestion came from an extraordinarily able collaborator and friend, Miss Rose Pine, an art teacher in New York. With her help and that of her colleagues it was not only possible to collect a large number of drawings and paintings of normal and abnormal children, but to make experiments with the aim of finding a method with which it might be possible in the most simple but systematic way to use child art diagnostically.

If one studies the subject matter of child art, one has at first the impression that juveniles of all ages, even more than adults, use motives from the outer world as their subjects. The small child portrays father and mother, the railroad and the streetcar, flowers and domestic animals, things belonging to its immediate environment. Older children have a somewhat more widened horizon, they paint the sunset, heroes out of stories, tales, and religious teaching, or the most impressive facts of their everyday life. Nevertheless, these juvenile representations are most expressionistic, quite expressive and very personal, telling much more of the inner life of the child than the best production of the average artist tells of his personal impressions. This is the unsolved secret of child art, that the little boy, in spite of having not the slightest training, is able to express so much in his primitive manner with pencil or brush. Usually this ability slowly disappears later in the adolescent period (44).

This extraordinary expressionistic quality of child art is something which must interest us diagnostically, and which I have tried to use to study such inner complexities of the child as are incapable or difficult of expression in words. We set ourselves the task of finding out if it might be possible to isolate elements of these complexities. Should we be able to succeed, we would then be in position to study the deeper regions of child-consciousness in its normal and abnormal forms. These ideas were met with attempts by Miss Pine and her colleagues, following a trend in modern art, to let children work at so-called "abstract" or "contentless" art. From a purely esthetic and art-educational viewpoint, they wanted to see what children would produce using only forms and colors without any obvious content. The result was astonishing—even terrifying—because this suggestion of abstraction caused the children to create things of the most crude realism, unveiling experiences which the teachers had never expected to exist in their pupils. Out of our collaboration in this research we developed a method of investigation which seems to offer insight into the deepest and most delicate spheres of juvenile inner life. It involves three separate elements or steps which I think should be called: (1) the exercise of abstraction; (2) the opening of the emotions; (3) the fact test. The reason

why this method, though indirect, is the best for obtaining true objective results will become clear from what follows.

THE EXERCISE OF ABSTRACTION

As has been already stated (89), impressions from the outside world are the predominant contents of all child art. If we want to unveil the purer psychic qualities of children, we have first to eliminate the impressions from the outer world, or at least push them into the background of the child's mental life, so that the purer psychic contents and imaginations will come into the foreground of the consciousness and be made the subject of artistic expression. This can be achieved by very simple and easily applicable training. We used for this an exercise in abstraction through which the child is forced to abstract for a short time impressions from the outer world, to concentrate on such factors and express them in pictures. The best means has proven to be the so-called "line analysis," well known to psychologists and educators. A series of words is put before the child and he is asked to express each one of them by a single line. It is best to choose words which are well known to the child and express rather intensive action or emotion. Furthermore, it is important to start the series with one or two easy to express, as "walking" or "dancing." Finally, it is best to make the series not too monotonous, but to vary words for very active with those for passive, violent, and peaceful contents. For an experiment with older children we used the following series: "walking, dancing, silent, happiness, depressed, fighting, thought, laugh, drinking, bark, lie, lovely." Children under eight should not be given more than ten words older ones not more than fifteen, so as not to produce disturbing fatigue. To get still further information, one can ask the children after finishing this first experiment, to write their own series of words on the back of the same sheet. After they have finished they may also be asked to draw a line analysis of these words. In this way we get to know the horizon which the line analysis has called up in the mind of the child. Even four-year-old children are, after a short time, able to understand the task. The exercise awakens the child's own activity, his own occupation and imagination. In this way the active relationship of the child

with outside experiences is subordinated; he has only his inner experiences in mind. This is the first step which can lead further toward studying the deeper regions of his inner life. Aside from the value resulting from such exercises, the line analyses have in themselves a diagnostic value which I can only briefly discuss here. As I have tried to show in a recent publication (89), we may distinguish special types of expression in them. We may, for instance, show whether an individual had a rich or poor formal phantasy and we may also recognize neurotic products without great difficulty. In itself, however, line analysis should not be used alone for diagnosis, as what can be seen from it is too general and abstract (Figs. 1-3).*

OPENING OF THE EMOTIONS

The second step in our diagnostic process consists of a new exercise by means of which the activity started by abstract drawing is brought toward and into the region of the soul or psyche from which come the contents difficult to express by word. Until now we have only exercised the ability to abstract by the use of simple and familiar concepts. Most of what we receive in this way is material which comes from the outer psychical regions. Those concepts, however, which are difficult to express, come from the region which we know as the source of the greater part of all psychopathology, that of the emotions. Even as the adult is generally unconscious of his emotional life, still more so is the child. The growth of the juvenile mind consists primarily in building up intellectual consciousness and its relations to the outer world. After emotional consciousness is to some extent developed, the clearing up and governing of the emotions by aid of the consciousness can begin. If, therefore, one wants information about the emotional sphere of the juvenile, and especially of abnormal juveniles, one must concentrate further than through line analysis and abstract emotional concepts from all other contents of experience. Only if we are able to concentrate the consciousness generally on the emotions, will it be possible to get any useful information about them.

For this purpose again series of words are put before the child,

* See inserts preceding this page for figure 1-43.

but the series should be composed exclusively of very impressive emotional contents; both positive and negative emotions should be equally mixed. Naturally this selection must be adapted to the age and experience of the children. For a group investigation with a class age thirteen to fifteen we used the following series, written on the blackboard:

<i>Joy</i>	<i>Pain</i>	<i>Delight</i>	<i>Grief</i>
<i>Suffering</i>	<i>Pleasure</i>	<i>Sorrow</i>	<i>Bliss</i>
<i>Luck</i>	<i>Harm</i>	<i>Gaiety</i>	<i>Distress</i>

The children are then asked to select one word, the contents of which they would like best to paint. They must be told they may use for this painting only colors and forms, no concrete objects. Thus they are directed to express emotions in abstract form. Even backward and mentally abnormal children and children under four are able to carry out this assignment if it is fully explained what they shall do and an example is given. Before each such exercise of drawing emotions, a line analysis should be done. The youngsters should be given time enough to choose their word as well as to execute their painting. Younger ones do best using crayons, older ones, water colors.

The value of this second step is that, after being trained to abstract in the line analysis, the child must now place before us his conception of his real feelings and emotions. And because he may not express them through facts taken from the outer world, we get them in some degree of purity. Very important for our diagnostic viewpoint is the kind of emotion the child selects, positive or negative. The youngster chooses such a word as he feels to be nearest his own inner life. Thus, a consciousness having actual or permanent tendency toward darkness and negative emotions, will make such a choice. This is the first concrete step in our diagnostic investigation; it gives uniquely valuable information. Often, however, one such emotional drawing does not mean much, for even a normal and gay temperament may have its mental sky darkened occasionally by a single sad experience; one negative result often means a not yet defined abnormality. Therefore, such emotional exercises should be done several times with intervals sufficient for forgetting the topic done before. A child who always chooses a negative subject over a period of succes-

sive exercises has without a doubt a dark undercurrent in his life, or at least a disposition in that direction. It is always important to avoid and counteract any distrust which might be aroused by the exercise. I have recognized that especially children of abnormal traits are easily suspicious of everything which might reveal their inner trouble. Phobic and depressive juveniles often choose directly; the most intelligent choose a combined topic and avoid telling anything of their inner life. Several such cases produced sheets done as "Sorrow and Happiness" or "Both Sides of Life" (Figs. 4 and 5). One can here be sure without further investigation that there is some disorder which can be exposed by repetition and by the third exercise which we shall outline.

Much more may be read from the child's execution of his emotions. I was never more astonished than when I first saw the results of this investigation. Juveniles have an unexpected ability to express emotions in pictorial form, even if mentally deficient and completely untrained in art. From a boy of fourteen suffering from an acute depressive neurosis, we received a drawing called "Sorrow" (Fig. 6), expressing in abstract form on the one side the gnawing and sawing, and on the other side the long-drawn feeling of pain. The insecurity, confusion, and disorder of a troubled young mind is easy to recognize in the formal execution of such pictures. Too, the quality of the abstraction is a measure of the mental development of the child. Youngsters who become interested in such abstract expressions are often not able to stop repeating them. It opens up for them a new language, which especially the very young are fascinated in exercising. We often received five or even ten such drawings at a time and had to stop in order to get the children to continue our analysis. This second exercise can be made much more valuable by asking the children to write on the back of the sheet an account of what they wanted to express. Such personal reflections are important additions to the paintings.

THE FACT TEST

The third step, already mentioned, consists in the direct unveiling of any special and individual abnormality which may exist. I have called this exercise a fact test, because it is devoted to

the revealing of factual circumstances. It should never be applied before a line analysis and an emotion exercise have been given. The fact test can be done in several different ways. It can be made with whole classes of schoolchildren—completely general. The children may be asked to paint in a realistic, not an abstract way, what has occupied them most during the execution of the emotional exercise. A form which proved successful with neurotic and unbalanced children is the fact test, together with a shock. Because the consciousness of such youngsters is a whole flood of unclear rudiments of thoughts, it is desirable to create a kind of analytical situation which calls up that thought which is nearest and strongest in the consciousness. After the emotion exercise the children are asked to rest a minute, with the suggestion that they may be tired from painting. They may be asked to put their heads down on their hands so they will not communicate with each other. Suddenly, by knocking on the table, their attention is attracted and they are asked to keep in mind the first thought that came into their heads. This is then to be given as the topic for the drawing. As an alternative one can choose any concrete topic about which an execution seems desirable. We have, among others, used the following topics: "What do you like best?" "What do you fear most?" "A dream you just had" or "The dream you remember best," "A nightmare," "What do you want to become in life?" "What do you like best in school?" "How the school should be changed," "Your favorite story."

Such tests are not only invaluable for general information about the inner life of the child but, as I shall further prove, give unique insight into juvenile psychopathology or tendency toward it. These results of these tests are impressive because they often reveal tendencies to abnormalities in children who seem to be completely normal. It is naturally fundamental to the application of such tests that one be in a position to use them for diagnosis, which means that one is in a position to interpret their meaning. A correct interpretation is naturally the major factor in the whole procedure. As I have said, it is quite possible to use the line analysis for diagnostic purposes and I regard it as more valuable than any graphology. It is always advisable to consider

the sheets of all three exercises together if one wants the most definite insight into a child's mind.

Naturally, for the interpretation of the fact-test sheet, the formal execution of the test is of equal importance with the contents themselves. First comes choice of contents, but color and form also speak an important word for the diagnosis. When a child chooses a subject difficult for direct interpretation, whether or not the choice is made with intention of concealing his inner life, then the formal execution of the drawing is the key. Unclear and diffuse presentation is then a symptom. Such drawings usually show backwardness as compared to the average drawings of children. A fine, developed sense for child art is the only guide to correct diagnosis, but experience is essential for its use.

One element which plays an important rôle in the fact test I wish to discuss more thoroughly. This is symbolic expression. There has been much written during the past years and much that is rather one-sided about symbols and their interpretation. But nobody has, so far as I know, taken any interest in the development and change in symbolic expression on the part of the growing juvenile. Those who today claim to have the best understanding of symbols, the pupils of Sigmund Freud, have made the mistake of considering the juvenile symbol from the same angle as that of the adult. What a child expresses and experiences through symbols is something quite different from the rôle symbols play in the life of adults. For adults symbols are a means of communication between individuals or groups about concepts which are difficult, or, for special reasons, unsuitable to express in words. Considered from the viewpoint of the user, their ultimate or final meaning is always directed toward the recipient. Symbols used by the child have not this final premeditation. They are merely a form of self-expression, a kind of monologue carried on by the child with himself. The infant has a natural tendency to express in symbols understandable facts which come into its mind, or to set outside himself experiences which bother him, because he is unable to understand them. If a fourteen-year-old girl with an acute phobia upon a schizophrenic background tries to express her fear of crossing a street by drawing a path through

the air supported by a post decorated with a kind of police eye, and adding a post of vermin to symbolize the crawling feeling of fear (Fig. 7), this is not painted as a communication for anyone else, but as a kind of "putting aside" for herself this disagreeable image. Had she wanted to communicate her feelings, she could have done it much more easily with words. Such experiences are often not even completely conscious to the youngster. This is especially true of the facts of premature sexuality which is met more often in child art than one would suppose. I have to acknowledge this, although I have opposed the too radical use of Freud's ideas in this field (74). It is true that forms of premature sexuality exist, but they should be explained in quite another manner than Freud's. They are the expression and outlet for the unconscious experiences of the ripening sexual organs of which the function cannot be understood before full adolescence is reached. Only after adolescence can a youngster know what sexuality means. I shall later give some examples of symbolic sexual expression in child art. Infantile symbols can already be found in the art of the four-year-old. If a youngster paints a colorful flag and, asked for the reason, says it is because it is a nice day and he is therefore glad and wants to paint a flag, this naturally has no final significance. It is only the expression of an individual emotion. It is now very important to recognize the development of this symbol and its change during the first two decades of life, and especially must be considered the development of sexual symbolism. Everybody knows that even children of the ages of eight and ten like to draw hearts filled with the name of a friend, a symbolic love-relation to another person. Such expression is the unclear utterance of the preknowledge of sexual relations. When later, however, maturity starts to stream through the body and soul, we perceive most impressively how elementary these forces are as they break into the inner world and try to hide in symbolic expressions. I have analyzed several such drawings with the children personally and can assure the reader that the youngsters had not the slightest understanding of the meanings of the drawings they had produced. Neurotic products from the period of adolescence are often characterized by a kind of shamelessness with which the child expresses itself.

Before I demonstrate with some characteristic cases our method of applying the fact test, I must discuss briefly some general points. Scarcely anyone who has made himself familiar with the fundamental traits of the art of the normal child has difficulty in distinguishing the abnormal. Most pathological products are poorer than average and more unimportant in their formal presentation and in their choice of contents. But here too one must be careful in judging because there also are normal children with little ability to draw or paint. Training will in a short time teach one to distinguish between the bad drawing of a normal child and the good drawing of a neurotic. Neurotic products always have a diffuse character; a neurotic child seldom has the balance or the restfulness to draw, which gives his picture special formal characteristics. The color of such neurotic products is generally gloomy and dull, often unharmonious and inappropriate. Neurotics often lack a sense of color. Let me repeat that abnormal children remain backward in their esthetic development. To recognize such things requires training, just as does scientific work in any other field.

For a fuller explanation of the interpretation of the fact-test results from abnormal children, I give here some concrete examples. If a special topic, for instance, "fear," is chosen, it will be easy to learn what is wrong, especially if the result of the emotion exercise is added to the examination. However, here too care must be used, for it may happen that a child who is completely normal takes fear as an amusing part of a thrilling sensation. In any case it is wise, if no clear conclusion presents itself, to give a free fact test to find out in which direction the inner life of the child is tending. It is equally important to find out whether one has to do with actual or latent disease, or a disposition to it.

Following are some cases. The prize winner in a school is a fourteen-year-old boy who, from his appearance seems to be a healthy young fellow. He is large and strong for his age. In class he is not a grind but lazy and a bully. He likes to tease the teachers and disobey. But in his work and studies he is always far ahead of the others. In the free fact test he produces a very unexpected and extraordinary sheet (Fig. 8). In the center of

his picture stands a slender little boy pressing his hands to his head in distress. His body is clenched in the fist of a muscular arm which reaches over the whole sheet and bears the inscription "English." From every corner dragons are storming on the little figure bearing names of other subjects of instruction: "French, Mathematics, Biology, Spanish." On the reverse of the sheet is a clear explanation, which we could easily find out ourselves: "I am the victim of my school's too many subjects and I am not the only one." Nobody would have expected that in the strong-looking prize winner lurks the sensitive and easily stung soul of a neurotic permanently in conflict with the exaggerated impressions made upon him, and therefore on the defensive against them with his bad behavior toward his environment and teachers—a characteristic case of defense neurosis. He would never have told his feelings directly to anyone, but in the fact test he spoke freely. This gave the opportunity to say what he had in his heart, which in his neurotic weakness he never would have said in words.

Such infantile neuroticism is not always so simply expressed. Here is a more difficult case. We have a little girl thirteen years old, very pretty, with blond curls and a sweet baby face, but she is extremely short-sighted and wears upon her little turned-up nose a pair of thick spectacles. She is unusually shy and bashful, with an almost pathological obstruction, which is surely the reason her schoolwork is not up to the average. In the free fact test she chose the topic "self-portrait," a topic which was suggested, to do in abstract form (Fig. 9). Her painting shows two large circles connected, with little triangles in the middle of each. On one of the circles is a large triangle which looks like a clown's hat. On the back of the sheet is the explanation of this curious conception: "The most important fact about me is that I have to wear glasses." If this little lady had complained of her spectacles in words, her mother would have taken her to an oculist; if she had complained that they made her look ugly, she would have been laughed at for her vanity or punished. The painting puts the whole situation in quite another light. Not the eyes, but the little soul suffers most and has begun to develop a definite tendency toward a neurosis, a tragic

factor in her development if it cannot be balanced at the right time. Only such a picture analysis could reveal the true situation.

Another sheet is done by a boy of fifteen who has a high degree of deafness. He paints a man lying on the ground, with an oversized head. The ear has no opening, but a kind of ladder strongly underlined in a dark color leads to the organ of hearing (Fig. 10). This makes it clear that the boy wanted to give some kind of a self-portrait. It is not unusual for a child to want to tell in such a test of his unfortunate disposition and related suffering. But there are other and more extraordinary things on this sheet. The man has not only an abnormal ear but also an abnormal eye, and the abnormality of the eye consists in its being much too large. Everyone knows that people who suffer from a physical inferiority of one organ try to compensate for this. An individual who is deaf develops the use of his eyes in order to get information he fails to receive from his ears. However, an eye, especially for a youngster, is limited in the force of vision and soon tires when such a compensatory strain is put upon it. Such eyestrain is expressed by our little boy in his drawing. That this is the meaning, another fact on the sheet makes clear. If one's eyes are tired of seeing, one tends to visualize everything in the form of a circle, as physically our sense of seeing is constructed. So our boy draws the house in the corner, not in square, but in circular form. Again our picture analysis gives information which would be difficult to obtain in so illuminating a way through any other kind of investigation. The child tells us clearly that, as much as from his ear disease, he suffers from the overcompensation of his eyes.

Paul is the seven-year-old, highly neurotic only son of a *nouveau-riche* family. The mother had two miscarriages before Paul, and he was born with ingrown sexual organs. The doctor promised cure through operation. Three days after he returned from the hospital his class was tested by our free fact test and Paul produced as his painting the very extraordinary picture of his mother in a pregnant state with tears in her eyes (Fig. 11). He called the painting "Pain." I am reporting this case as it happened and I know that Freudian psychiatrists will regard it as

an excellent argument for their theory of infantile sexuality. I cannot but confess that we have here a case which this theory seems to fit, but I wish to add that there are also other possible explanations. I am sure that in Paul's home there was much talk of the events of birth and propagation and that he had heard much about them. Maybe, too, some explanations about the sexual organs were given him because of his operation. There is no doubt that the pain of the operation is reflected in the suffering of pregnancy and birth. Such a painting tells most impressively how tragic such experiences are for a young soul.

Gloria is a ten-year-old child of a large proletarian family. About nine months ago she lost her father. She is slender, anemic, and highly neurotic, noticeable in class because of her restlessness. She is kind of friendly but somewhat shy. She regularly attends the free class for drawing where we conduct experiments. In this group it has in some way become the mode to draw little fashion figures. Gloria's sheets are unusual because some of her figures have no heads. By watching her draw, we see that she always starts with the neck or feet and obviously has an inner fight to put a head on her figures. Once in a while she copies a head line by line from a neighbor, and if she completes one, its eyes are closed or tears are streaming from them. The fight before she starts to draw a head takes up to fifteen minutes. This peculiarity was explained when investigation disclosed that her father had been killed in an automobile accident and his head completely crushed. The child, who had seen the body, received a shock causing her unfortunate mental state. To use the terminology of Carl Gustav Jung, her "father image" was disfigured by this tragic impression which she is unable to forget. This cruel case could only be revealed through observation and study of the drawings of this child.

The following difficult case is of a sixteen-and-a-half-year-old boy whose school record is that of a fourteen-year-old. Nothing could be done with any educational measures. No one would believe that this "discipline case" has a severe neurosis which first came to light in a drawing analysis. We would let him do a longer row of pictures which were extraordinary from a viewpoint not yet mentioned here. His drawings were of a perfect

stylistic uniformity, although he is far from having artistic abilities. A remarkable factor in all the art of children, even those four or five years old, is that if they practice drawing and painting for some time it shows a perfect individual formal style just as does the art of well-trained artists, with the same formal expression and uniformity of color. This strong personal note in child art generally disappears after adolescence, if not specially cultivated. This boy showed his "style" in a muddy-colored picture with black as the underlying tone. In his first emotion test he already evidenced a conscious desire to veil something. He chose the title "Joy" (Fig. 12) for a picture which was far from being joyful. The latticework in muddy color on a black background, was more similar to a view from a prison window than to anything else. After giving him some time and opportunity in half a dozen drawings to free himself, he showed something of his inner situation in a sheet he called "Woods by Night" (Fig. 13). It was a scene of a man standing between trees on a black background and diabolic heads everywhere looking down on him; even the trees had eyes. The sheet showed clearly his neurotic state as a case of an oppressed and persecuted soul completely drowned in the corresponding neurosis, which could also be recognized as the psychic motive in his other drawings. All the mistakes and bad behavior of this boy were caused by a mentally unbalanced disposition which he was unable to overcome. Only such careful and rather lengthy picture analyses showed the way to finding the real background of the child's troubles.

I wish to add finally, a paragraph on the products of adolescents, the delicacy of which one must be especially careful in distinguishing: 1) Sane, somewhat expressed erotic; 2) insane, early maturity; 3) strong, but not directly abnormal sexual disposition; 4) direct sexual pathology. The greatest tact is needed for correct interpretation. If a thirteen-year-old boy portrays himself and a man burning in hell fire, together with a little angel vanishing in the sky, and the text on the back of the sheet "I am burning and you let me alone," it is not difficult to see here a very realistic psychic picture of the first pains of eroticism. More difficult are interpretations of pictures of the

dreams of a little girl who sees herself persecuted by a "pink" elephant with a long trunk (Fig. 14), or scared as she lies in bed (Fig. 15) by a "pink" cat with a long neck trying to force its way through the window. Here I think we can hand the task of interpretation over to the Freudians.

Similarly, the dream picture of a fourteen-year-old boy is surely nothing but a symbolic representation of a pollution when he sees a big red watering pot out of which little human beings are blown into the air (Fig. 16). All such products, it seems to me, can in no way be called unnatural during adolescence. An unnaturally strong sexuality shows itself in quite other forms. For instance, a sixteen-year-old girl, two years behind in school, whose strong erotic disposition is expressed in her whole appearance, paints in the fact test a picture which she calls "A Salty Lunch" (Fig. 17). But this title is only a cover-up. Considered in itself it is an expression of a strong sexual wish, an interpretation which becomes verified by studying some of her other pictures in the analysis (Figs. 18 and 19). In such cases it is not only always wise, but necessary, to study a number of drawings of the same child. As already mentioned, one of the most expressive traits of infantile sexual pathology is the unveiled shamelessness shown in the pictures of such children (Figs. 20 and 21). I have found exposures in different forms and even copulations, usually of animals. Also the rest of the contents of such sheets describe clearly the pathology of the child. Other such pathologies are only in themselves symptoms of infantile schizophrenia. One of the most extraordinary sheets of this kind is a landscape with a giant lying in the background with the sun as a head, the mountains as a body, decorated with a male sex organ (Fig. 22). But the rest of the picture also shows clearly that it is done by a pathological mind.

A word now in conclusion about these examples. It was stated earlier that the interpretation of the products of juvenile psychopaths must always start with some knowledge of the pictorial creations of a normal mind of a certain age. Furthermore, one must have some understanding of the somatic peculiarities of the most frequent mental diseases, as well as some knowledge of the fundamental psychiatric and psychological theories applied

today to the understanding of mental diseases. I must here again emphasize what I have said so often: I believe one must apply different theories in different cases for an understanding of the manifold mental abnormalities. I have consciously chosen in this chapter cases suited for explanation by the theories of Freud, Adler, and Jung, to be used side by side. Others may also be used, but to demonstrate them would lead us too far. Naturally, also, the environmental, physiological, and genetic factors which may be involved, must be carefully examined. I wish to close with the maxim, that the application of this new means for psychotherapy, that of child-art diagnosis, should itself be considered as an art of diagnosis without which no medical man and no psychologist can be a perfect master in the "art" of understanding and helping broken and disturbed human souls.

IX

TRANSITIONAL THERAPY*

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SOME TIME AGO I conducted an authorized investigation with a group of children who were patients at the Kings Park State Hospital, Kings Park, New York. This research represents the preliminary study for a larger project concerning the importance of art expressions in the diagnosis and therapy of juvenile schizophrenia. In addition to the originally designated group of Children I observed a young patient in the same ward who, although he did not belong to the above category, revealed symptoms so significant in the scope of the projected investigation that it was decided to devote a special study to him.

Case—

The case of M. is one of the seldom observed occurrences of subconscious collective symbolism, the bringing of which into the sphere of interest and research in abnormal psychology has been one of the great achievements of Carl Gustav Jung (111). When Jung first pointed out the appearance of such symbolism as a deciding factor in the mental life of the insane, his colleagues ridiculed the idea, but since then the importance of his entire theory of collective subconsciousness has been recog-

*A considerable time after the experiments which are described in this chapter were executed, the author decided to select as name for the method applied Transitional Therapy. As the reader will realize, the method applied has a certain similarity to the sublimation concept of Freud. However, there are basic differences which I prefer to have the reader find out by himself. To make this difference definitely clear, I have chosen the different term, a term which seems to me also to express much better what is actually experienced by the patient.

nized by many serious students of normal and abnormal psychology.

In the case to be described special emphasis is placed upon the rôle of the symbol in the inner life of the patient and on the therapeutic procedure employed to free him from a pathological subconscious collective symbolism.

M. was born in May, 1935. His parents were immigrants from Eastern Europe. The father is a psychoneurotic who works only part of the time, as a taxi driver. The mother is also a neurotic bearing stigma of a difficult family life. The elder son of the couple, born in 1928, has been in a mental hospital for many years diagnosed as a schizophrenic. There is a record of mental illness among the relatives of both parents.

Because she had already had one mentally diseased child, M.'s mother had taken "abortion pills" during her pregnancy, but M. was born at term. He was not breast-fed, and an incorrect formula caused diarrhea lasting several months. He had whooping cough at eighteen months, and chicken pox when he was two years old. He started to walk and talk at the normal age. According to his mother, he fell at the age of 18 months, striking his head on the floor, and she states that from this time his growth was retarded. She reports that he was always a sickly child; he had "running" ears when he was four weeks old. As he grew older he became more and more difficult to manage: "He never obeyed and was very wild and demanding." He was sent to school for a short time but the principal requested that he be kept at home. Apparently school disturbed him a good deal; however, he managed to pick up a considerable amount of elementary knowledge. In the period between school and institution he became more and more uncontrollable. "He fought with everyone, he hit himself, he made an attempt at suicide"—the latter not completely proven—"he began to fear the dark and to talk about ghosts."

In 1943 he was brought for observation to the Psychiatric Division of Bellevue Hospital, New York City, where he received nineteen electric shock treatments. Since his mother refused to take him home he was admitted to Kings Park State Hospital with a diagnosis of mental deficiency with behavior disorder.

The behavior symptoms consisted of constant restlessness and teasing the other children. He talked constantly, either to himself or others, expressing his distrust, aggressive demands, and restless paranoiac curiosity. The only way to control his physical restlessness was to give him a piece of paper and a crayon or pencil. He filled the paper with small drawings using the pencil so violently that it frequently pierced the paper. These drawings were the feature which attracted my attention to the boy. Most of them were symbolic in character: flags, national emblems, religious and other symbols which would be familiar to simple-minded people.

In my study of the case I did not start with any preconceived pathological or psychological theories; my aim was simply to discover the impulses which called for such intensity in the boy's pictures and why he expressed himself in such symbolism. There was no specific intention of inaugurating a cure by art therapy; the idea, at first, was to let the boy express himself and to observe developments.

The first approach was rather difficult. When invited into the small office he became suspicious. He looked under the paper which was given him for drawing, and under the table, and ran like a caged animal up and down the room. After vain attempts to explain that we only wanted him to enjoy himself drawing, he had to be sent back to the ward.

The second attempt, a week later, was more successful. He understood what to do, hastily drew first his usual small symbols, and then continued to write nonsense syllables to which he gave his own meaning which changed from one reading to another, and hieroglyphic representations of his own name and address. When he jumped up and became restless again he was sent back to the ward.

The third time his behavior was quite different. He came eagerly into the room and sat down immediately at the table as if expecting to be given pencil or crayon. When he entered the room he was engaged in an incoherent conversation about fighting the Japanese and Germans, which he continued after sitting down. When given drawing material he drew in rapid succession several unarticulated war pictures of the type of (see figure 23).

Between the drawing and the conflict in his mind he grew more and more excited, until suddenly he addressed me as follows: "Getting after me, getting me killed," and with increasing excitement he began to repeat over and over a vulgar word referring to intercourse, which he wanted to have with me, with his nurse, the attending doctor, and also with his father. This was followed by violent jerks of his whole body, during which he hurt himself so severely that he fell down crying. As a consequence he was sent back to the ward.

During a fourth session, at which he produced the same type of drawing (see figure 24) and exhibited the same type of release attack, an attempt to calm him down with kind words and petting produced the reverse of the desired effect, only making him wilder.

During the following session (there was always an interval of one week between sessions) I changed my attitude. In general M. presented the same behavior pattern although he was somewhat less excited. In the course of the first drawings he roused himself to a similar attack but when he started to hit himself I stepped behind him and with gentle force held both his arms while talking to him quietly. After the first violent resistance, he suddenly calmed down, discarded the last unfinished drawing and started another on a fresh sheet. He produced a drawing rapidly, without saying a word. After completing the drawing he was so exhausted that he had to be led back to the ward where he sat in a corner without moving or talking, with his hands pressed between his knees, for about an hour (see figure 25).

His drawing was an amazing presentation of a very common medieval alchemical symbol representing, in the alchemical bottle, a picture of the sun and the moon in a relationship of what can only be called cosmic sex communication. The literature of the Middle Ages contains a great number and a considerable variety of such symbols. There are even entire series expressing the contemporary conception of the creation and constitution of the cosmos, the earth, and the physical and mental nature of man. In particular, the inner change and development, healthy as well as unhealthy, were expressed in this symbolic language which, because it represented the psychology and even psychi-

etry of that period, has attracted the interest of students of modern analytical psychology. From this standpoint I devoted considerable attention to these documentations of the Middle Ages, especially during the time when I was a collaborator of Carl Gustav Jung. His recent book, "*Psychologie und Alchemie*," contains not only a great number of such sun and moon intercourse drawings of alchemical origin but an introduction to the meaning of this psychology and philosophy. In figure 27 a few such pictures are reproduced from alchemical manuscripts 875 and 8552 from the *Librarie de l'Arsenal* in Paris. Anyone who wishes to see some of the original material is referred to Barkhausen's "*Elementa Chymica*," Leyden, 1718 and Grillot de Giory's "*Musée des Sorciers*," reprinted in Paris in 1929.

The patient's drawing represented the sun and moon in the magical bottle, together with two very small circles such as are found in similar alchemical drawings. In addition to this main concept there was a smaller bottle apparently showing sun and moon in completed relation as in many of the original old drawings. There were also two sets of numbers similar to those known as number symbolism, for instance in the so-called "Hexen-Einmaleins," one of which appears in Dürer's famous etching "*Melancholia*." It is not our present task to interpret the meaning of this entire symbolism and its apparent rôle in the patient's subconsciousness, but to present actual occurrences. Interpretation will be attempted in the second part of this paper.

During the rest period which the boy took after completing the drawing just described he sat in the occupation section of the ward which could be seen from the experiment room. As soon as he showed a tendency to activity he was called back to the experiment room and asked to continue making pictures. He accepted this suggestion willingly, drew first a few forms of alchemical bottles, none of which he completed, and finally drew the picture in which there are two bottles clearly recognizable with the sun and moon apparently in a reproductive union. This drawing proves beyond doubt that the third drawing also represents the sun and moon inside the bottle. An interesting feature of the fourth is the set of nonsense letters and, below, the attempt to remember letters of the regular alphabet (see figure 26).

There can be no doubt that these alchemical symbols were recalled to the boy's mind by some kind of abnormal remembrance as an expression of the collective subconscious and that they had some connection with a pathologically precocious sex consciousness. An investigation of these relationships was attempted in the next session.

When, a week later, the boy saw me enter the ward, he hurried to me and wanted to be allowed to draw immediately. He was rather active but his mind seemed clearer and he had more self-control. He did not talk in his former incoherent fashion. Before being given paper, his drawing of the magic bottle (see figure 25) was shown him and he was asked: "Who did this?" and "What does it mean?" He smiled for the first time and answered: "You know I did that." When asked again what it meant he would answer only: "You know." When praised for his good work but asked to tell why he had done it he became aggressive, saying: "Was this good? I fucked you a good one . . ." When finally given paper, the following remarkable symptom appeared: for the first time since the observation began he was able to write actual words and even his name, eagerly filling two sheets. He then drew several confused lines, but he also tried to draw several bottles containing nothing symbolic. For experimental purpose he was shown several photographs of nude Greek statues of both sexes and was asked to tell which were men and which women. He mixed them up completely, showing that he understood nothing of the actual physical sex characteristics. Immediately after this experiment he produced in (see figure 28) a version of sex difference in the form of outer dress. However, it may not be exaggeration to designate the design beside the woman as a vaginal symbol.

By this time there was definite evidence that M. was better able to express himself by drawing than by intellectual expressions. It was also obvious that if given the opportunity to express himself by means of such drawings he would release such subconscious symbolic elements and thus free the mental parts of his psyche. Apparently through such activity he was liberated from the pattern of "hauntedness" and "possessedness." (This unusual language is used for the purpose of a connection with the

later interpretation of the case.) There was overwhelming evidence that such release of subconscious symbolism had an amazing influence on his entire existence. Not only was he less restless, but he began to remember incidents of his earlier life before he had been overcome by this condition of almost total amentia. He was also able to understand and remember what the other boys in the same ward said.

The beneficial effect of his drawing activity became increasingly evident during the following weeks. His drawings show how purpose slowly emerged from chaos. His drawings also became more organized and better planned. He began to print his whole name on his pictures. The inscriptions on the drawings are mostly more or less incorrect names of the other boys in the ward. The intensity of his subconscious preoccupation with sex also finds expression in one of the inscriptions and in this connection one observation must be made here, since it will be of great importance later. Practically all the drawings have as the central or dominant element either a long form, designed as an airplane, or tree stump, etc., or a wider oval or rhomboid form, mostly designed as a ship (see figures 29 and 30). When asked the meaning of these two forms, the most intelligent answer he could give was to call the long form "He" and the rhomboid form "She." There is little doubt that these forms represent roughly symbolized sex patterns which in their physical appearance the boy would not recognize. Some kind of symbolic expression is doubtless involved in each of these drawings, working itself from the subconscious to an individualized expression.

The sessions were discontinued for three months. The report of his behavior during this interim was not satisfactory. He soiled himself again, was aggressive and disagreeable with his ward companions, and extremely noisy. However, he did not seem so mentally disturbed as before the sessions were started nor did he run around aimlessly but spent most of his time looking over the same comic magazines. The supervisor reported that occasionally M. asked the attendant the meaning of a picture or word in the magazines. When I entered the ward he recognized me at once and evidently expected to be called to the experiment room.

In resuming the sessions with him, the former attitude was used. He was asked whether he would like to draw and he responded with great eagerness. At first he produced the same motives, mainly the two major symbolic forms but there is a fundamental difference from his earlier pictures. They are much simpler, clearer, less confused and less violent, although during the first session he began to excite himself again to the verge of an attack of aggressiveness which, however, did not reach its full development (see figures 31 and 32).

At the beginning of the second session he was shown his original sun and moon drawing (see figure 25), his reaction was quite unexpected: he burst out crying, saying that he did not want that again. When asked why, and whether he knew who drew the picture, and why he was afraid of it, he stopped crying, looked at it with interest, and replied hesitatingly, "I guess I did it." Without any further remarks he started to draw. The first picture has an interesting inscription doubtless derived from his reading of the comics, together with one of his typical attempts to clear his intellectual restraint by writing the alphabet (see figure 33). The next drawing again shows the sun and moon symbolism, but in a more natural, realistic setting (see figure 34). They are placed in the sky and a star is added. However, he apparently had to overcome some resistance in producing a materialistic setting for this symbolic expression, as evidenced by his crying at the beginning of the session. Frequently he wrote the word "moon" on the drawings, later substituting the word "sun."

The change from a "moon predominance" to that of the "sun" became increasingly important in the boy's developmental experience during the next few weeks of our working with him. The day after he drew the more naturalistic drawing he suddenly remarked that he wanted to draw a man and demanded colored crayons which had always been on his desk but which he had hardly ever used. The result was (see figure 35), a figure in which the hat and abdomen are colored yellow. The inscription derives from the comics, but another experience seemed to be involved whose meaning later became clearer.

During the new series of weekly sessions in which he was merely urged to draw what he pleased a profound change oc-

curred in his entire behavior. This was so obvious that it was reported spontaneously by the ward attendants. He almost completely abandoned his attitude of restlessness and usually sat alone in a corner, leafing through the comic books and magazines provided for the children. Occasionally he asked the attendant or the nurse questions regarding the pictures he had just looked at or about the simple facts of life in his present environment, expressing the greatest astonishment at what he was told. One of the most impressive of his questions was "Are not all these boys sick?" He seems to have suddenly become aware that he was in an atmosphere of insanity. This and other questions indicate that at this time he began to emerge from the darkness of his condition of dementia or amentia and to waken to a new mental life.

Three drawings were made during the next session (see figures 37, 38 and 39). They show an increase in the entire mental awakening process. The first drawing shows, in the middle, a strongly emphasized sun attacking a half moon. The inscriptions are still chaotic but a careful analysis would probably find some meaning in them, proving as does the total character of the drawings, a slow intellectual recovery. In the next attention should be given to the inscription which contains the word "today," with the boy's own name "Melvin" and the word "man," which seems to express the assurance of progress toward the "end" which is also in the inscription. This "end" is clearly expressed in the last where we find the inscription "Scott—end." Scott was the name of the head nurse in M.'s ward. The boy expressed a definite feeling that he was drawing near the end of his illness of which he was now aware, or at least his mental awakening had progressed to the point where he was aware of his condition and aimed toward its ending. The last drawing also contains the sun picture as do almost all of this new series, but here it can be clearly recognized in its symbolic character. It is not the sun in the sky, but the sun in some kind of symbolic action which is definitely expressed in the way the sun and moon pictures are placed in the drawing. Incidentally, no more nonsense syllables are present. No more periods of excitement occurred during the sessions, only a slight intellectual struggle when he was asked to leave

the experiment room and return to the ward, which is readily understandable. Finally, the ward attendants reported that he was behaving well and seemed to be improving rapidly.

During the last two reported sessions the boy had wanted to fill all the drawing sheets with words instead of "doing pictures." Only by special urging and even threatening to send him back to the ward induced him to do what we were interested in, but this tendency was not only a specific indication of what was going on in his mind but an important part of the entire process. Drawing was for him now "always doing the same" while the ability to rationalize and express himself by writing words meant much more to him. In studying these word-filled sheets, such as figure 40, we first notice a steady advance to clearer and more correct reproduction of the intellectual content. Another interesting feature was the tendency to produce series of words which had a certain connection in their meaning, such as the days of the week and the names of the months. There were also words of closely connected things, such as domestic animals, and words with the same rhyme endings. These obviously represented the boy's desire to reconstruct his former systematic and organized knowledge which he had lost during his illness. However, it should be mentioned that such systematic series are very common in the medieval pictorial philosophies in which the sun-moon symbol had its actual rôle.

The boy seemed to feel the importance to his inner development of this knowledge of the word series. He shows this very plainly in his drawing. He first started a week series but "got lost"; he therefore writes "lost job." Under the correctly completed series he gives himself the evaluation "good work." The difficulty of his struggle to find the way back to consciousness is shown by his search for the right word. First he writes "Goodness"; then a little later his slowly awakening mind finds the right expression, "Good work" (see figure 40).

The drawings of the last period of my work with the boy all show clear signs of a clearing up of his disordered mind. One of them expresses clearly his urge for an "exit" from what he now considered a kind of imprisonment (see figure 41). Some days earlier he had asked a nurse whether being in this ward meant

being in prison. In this drawing, sun and moon are again represented in the basic connection but predominance is given to the sun. In several earlier drawings the sun is alone. The predominant role of the sun in the development of the boy's mental concept is more and more evident in these last drawings, which show the sun and moon relationship but, at the same time, the sun as a dominant factor alone. An example of the final development is the drawing showing the sun only. An entire series of such drawings was produced during the final weeks of the collaboration. He even signed the drawings with a sun, adding a few little strokes instead of his name. Once he even pointed to such a sun signature, saying: "That is me" (see figures 42 and 43).

During these final weeks his entire personality structure changed: he even showed a little friendliness and cheerfulness. The specific earlier symptoms of behavior disorders and dementia faded away. His behavior pattern was still one of insecurity which can be easily accounted for by his years of mental confusion and the divergence of age and mental status. His mentality was still retarded and he spent most of the time sitting around and looking through magazines and comic books. He asked the members of the staff many simple questions characteristic of the infantile "question age."

Our report and the reproduced drawings show without a doubt that these drawing exercises produced a fundamental change in the boy's pathological condition. Furthermore, we believe that our method of applying the drawing exercises—of which we shall speak later—improved his mental status. There can be no doubt that we freed his intellectual abilities which had been submerged in a dementia which our treatment did much to improve. Our previous presentation gives no indication as to the actual abnormal process in which the boy was found or the background of our therapeutic influence. In the following pages we shall attempt to clarify these problems.

SOME METHODOLOGICAL CONSIDERATIONS

The use of so-called art expression in work with children has become a very common procedure. It is applied for occupational and pedagogical purposes, as well as for the diagnosis of nor-

mal abilities and abnormal traits, and particularly as a psychotherapeutic media. In comparison to the tremendous quantity of its application, the amount of thought, or even philosophy or psychology, devoted to it is infinitesimal. Naturally, theories have been developed regarding the value of child art but these theories have nothing to do with its actual rôle in the mind and life of the child. Some of the best known general theories are the most impossible, such as Goodenough's (63, 64) attempt to evaluate children's art in accordance with the degree of reality attained. It is amazing that a professor of child psychology should not realize that a child's mental world is not one of natural science based on experience but is one based on imaginative fantasy. Another theory is that which attempts to explain every child's drawing. The worst of these concepts is Laurotta Bender's (18) in the application of a Freudian supersexual theory to explain children's imaginative play drive. To really understand children's art and its psychopathic deviations, it should not be approached with theories outside its own world. We must understand the psychology and esthetics of children's formal desires because they alone provide a sound background for understanding such utterances. Few workers in this country have attempted what the great founders of these studies undertook twenty-five years ago—a fundamental study of art and child art and the art expression connected with abnormal behavior. At the time when G. F. Hartlaub, in "*Der Genius im Kinde*" (93), made the unique attempt to understand the genesis of infantile art expressions, and Prinzhorn (154) published his books on the art of the insane and criminal, I started my study of child art by attempting to combine the ideas of both. However, not until recently have I felt justified in publishing my conclusions on pre-esthetic form types. Really serious research in this field, as in any other, takes a lifetime to produce valid results. Many papers have been published describing the various aspects of such a basic issue and attempting preliminary or final solutions of specific questions. My studies of children's humor and children's religious expressions have tried to clarify the preliminary problems of the infantile creative effort. Only if we discover how a child really expresses elements which he cannot express rationally in words

shall we find the clue to the formal and pictorial sense of the child. We are far from a final understanding of these facts.

We have already explained that our case of a demented child's unusual pictorial expression is not presented merely as an interesting case history but for the purpose of a basic consideration of the involved scientific aspects. Methodological aspects are first considered; they concern the relationship of such expressions and similar ones from an earlier period of human development. For this purpose we put aside the question whether our patient's drawings should be called art or evaluated esthetically. We may call them child art but we are only interested, in addition to their psychological and psychopathological significance, in their anthropological or rather anthropological-historical relationship. In the first place, these drawings *were not merely play*; they meant something very serious and unusual to the boy, expressing elements in which he released inner experiences which he was not able to express in other ways. For some reason he had lost his capacity for intellectual expression normal for a child of his age. His first drawings were of a definitely symbolic character. They expressed—or tried to express—ideas (flags, emblems, etc.) which are difficult to say in words.

Some anthropologists have studied such pre-intellectual expressions of prehistoric and primitive men who had a similar symbolic and pictorial language long before our letter languages were developed. Some modern students have tried to compare these primitive drawings with those of children. A very simple test shows that there is little to gain by comparing such anthropogenetic products with infanto-genetic ones. To be scientifically exact we can only compare works by children of primitive people with those of our own children. Those who have made such attempts have presented some rather amazing results. They found that the products of children and primitive tribes (Eskimo, African, Indian) were of much higher quality than those of our children of the same age. Excellent studies have been made by Rivers (158, 159), Malinowski (135, 136), Westermarck (180), and others. They explain the technical and esthetic maturity as well as strength of expression in such primitive children's drawings by the training they receive in handiwork almost from the



Figure 1

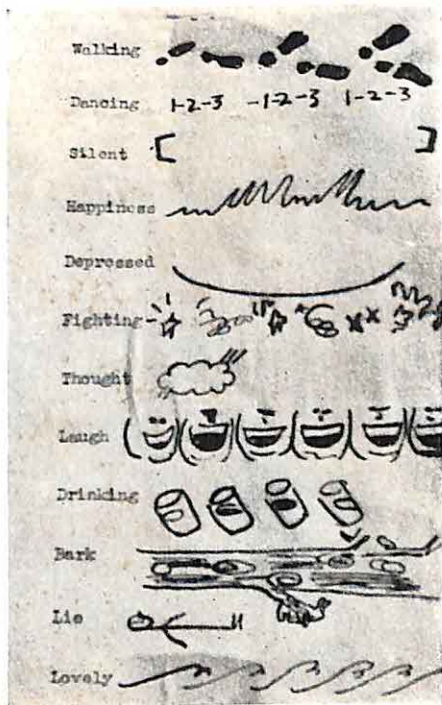


Figure 2

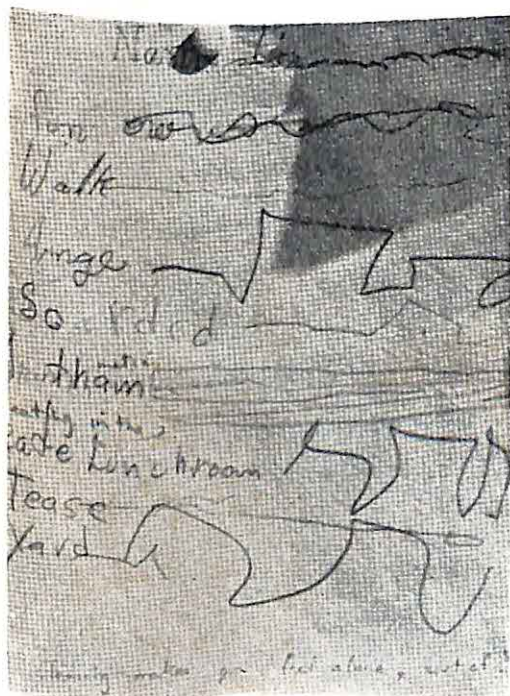


Figure 3



Figure 4

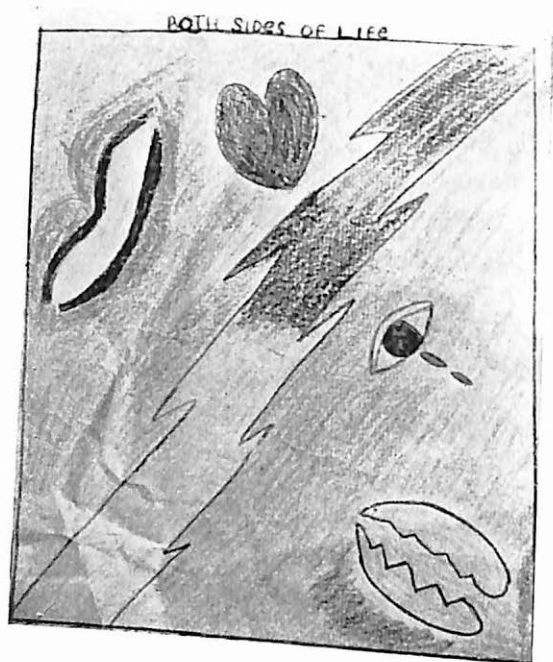


Figure 5



Figure 6

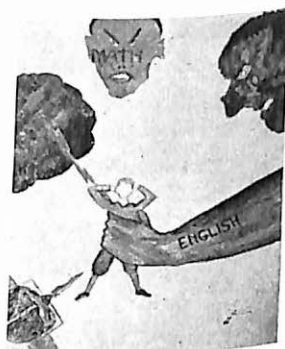


Figure 8

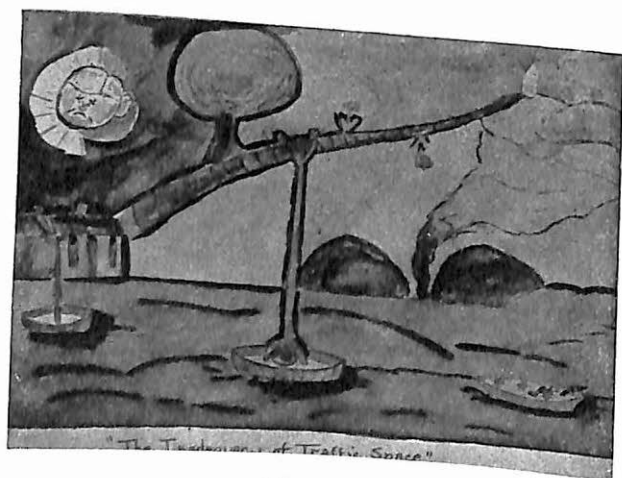


Figure 7

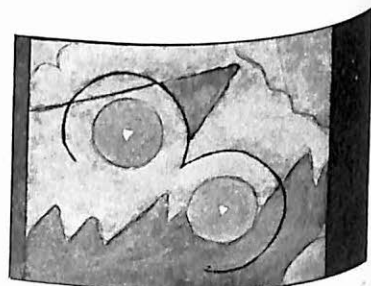


Figure 9

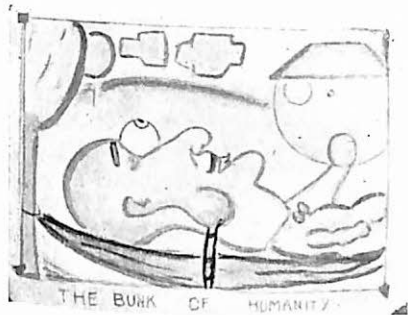


Figure 10



Figure 13



Figure 11



Figure 12

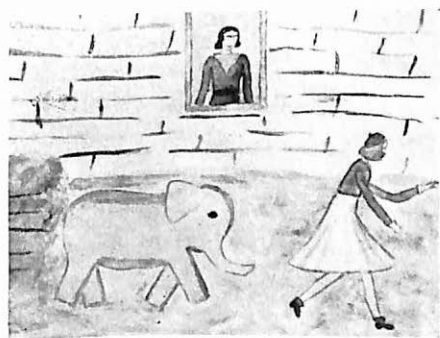


Figure 14

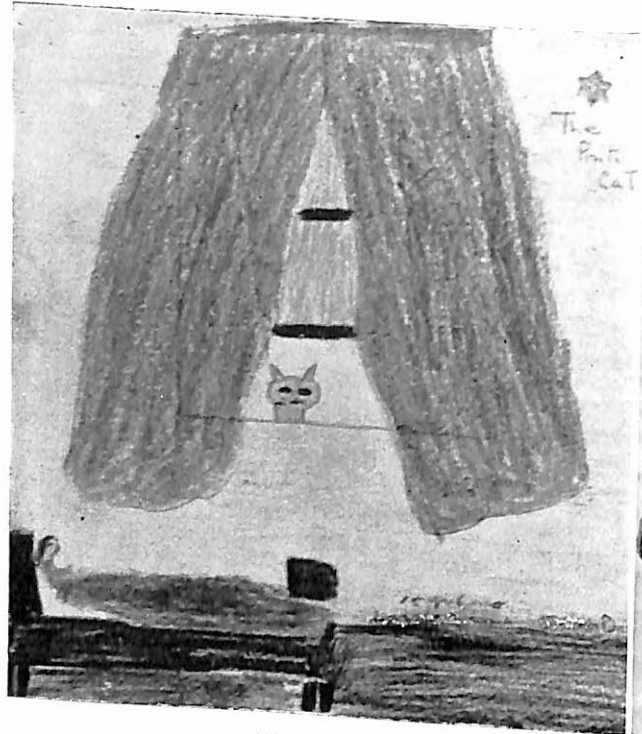


Figure 15

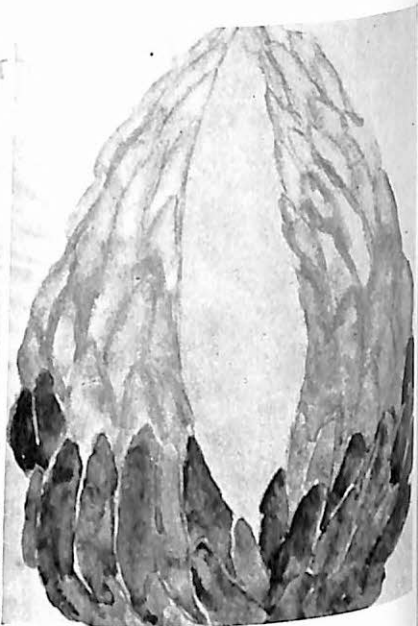


Figure 18

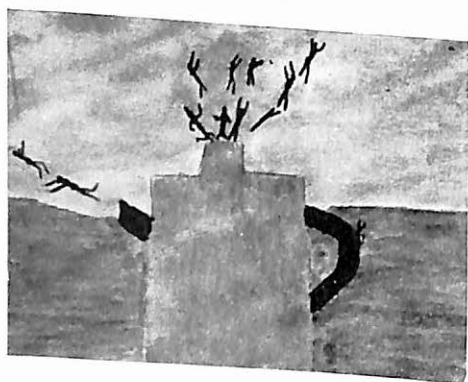


Figure 16

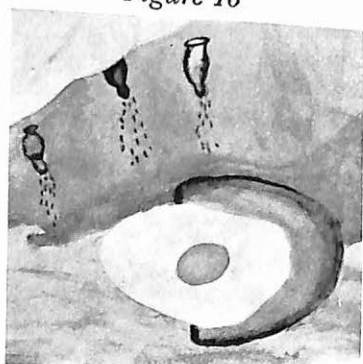


Figure 17



Figure 19

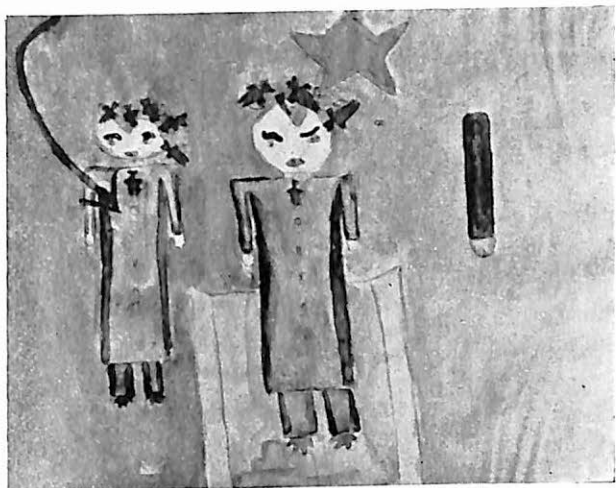


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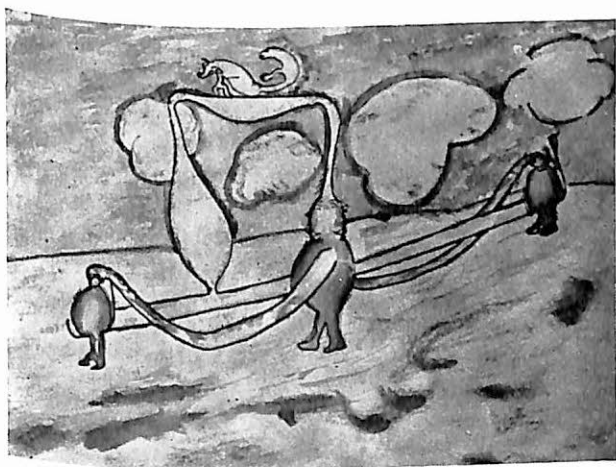


Figure 21

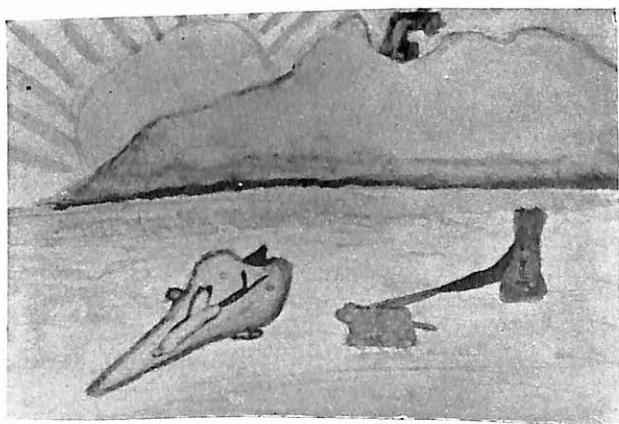


Figure 22

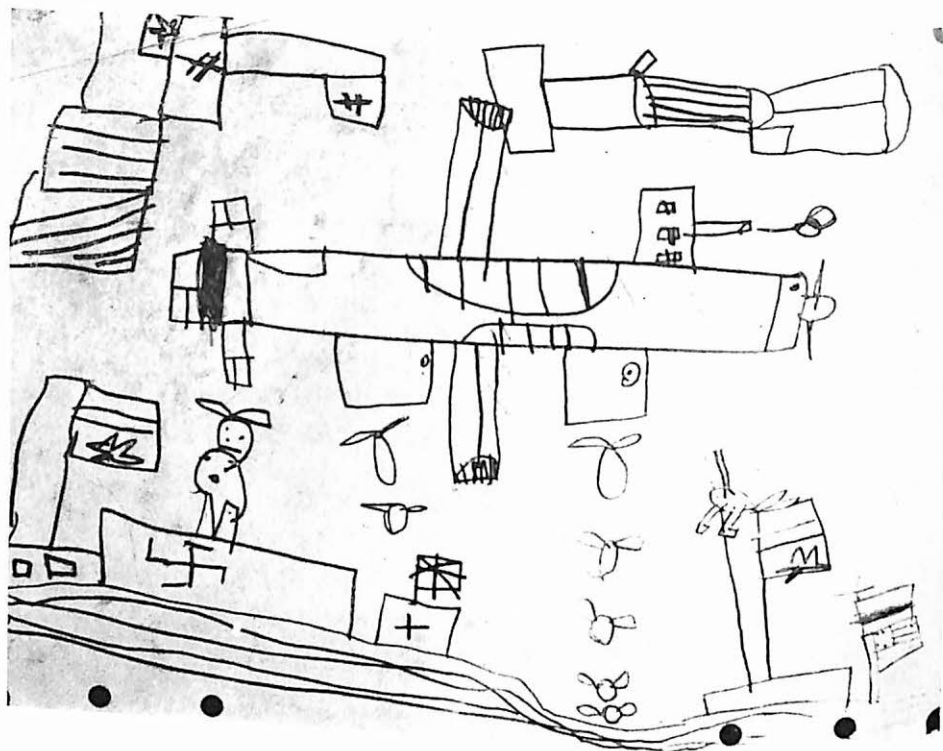


Figure 23



Figure 24

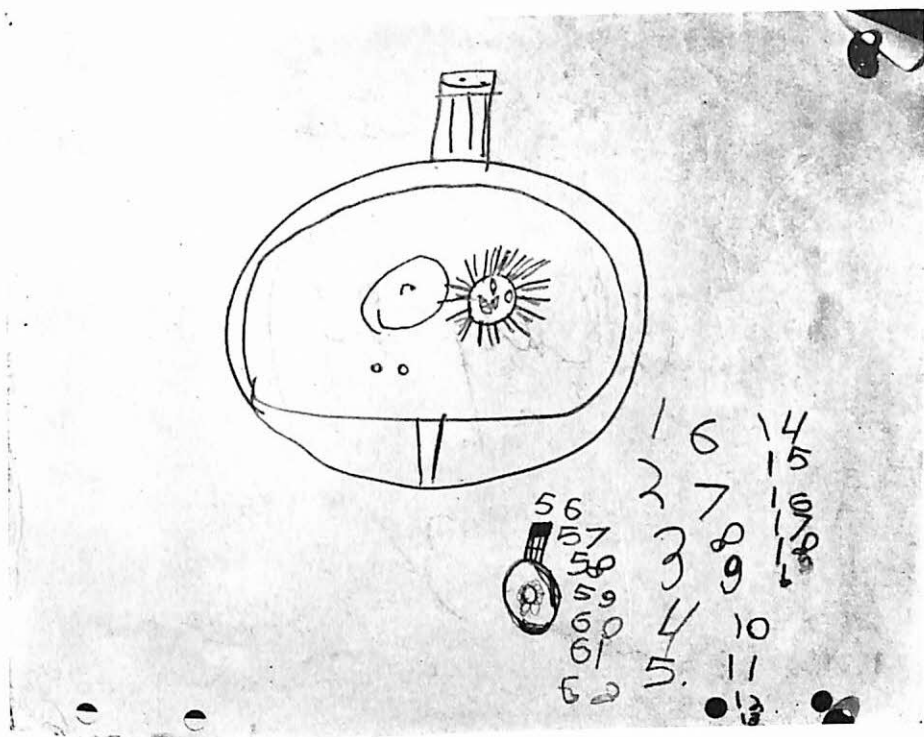


Figure 25

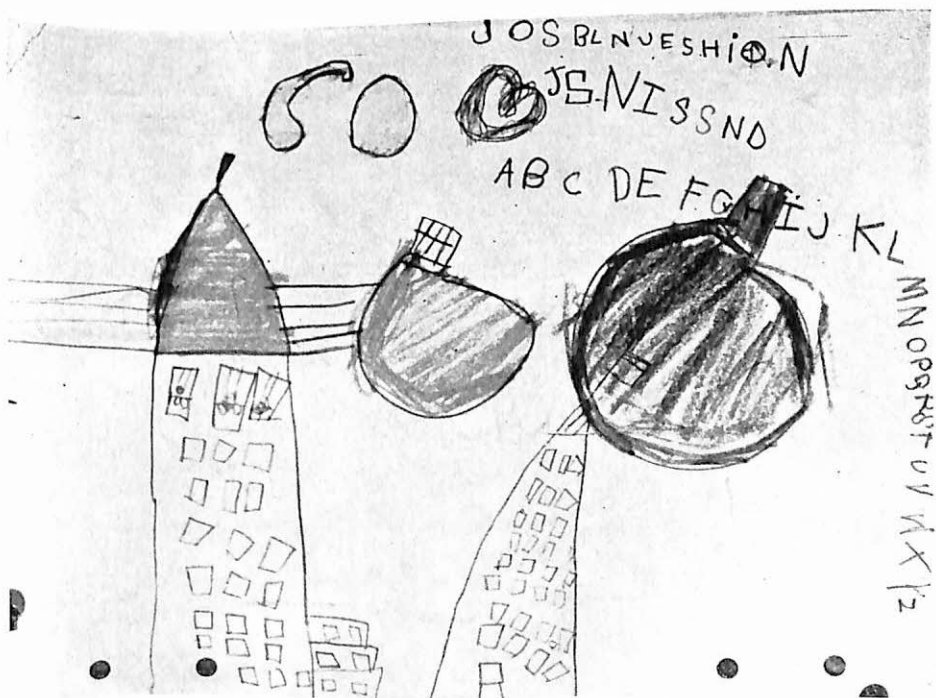


Figure 26

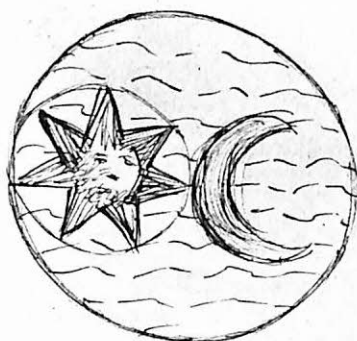


Figure 27

Melvin Franklin
 June 3 1944

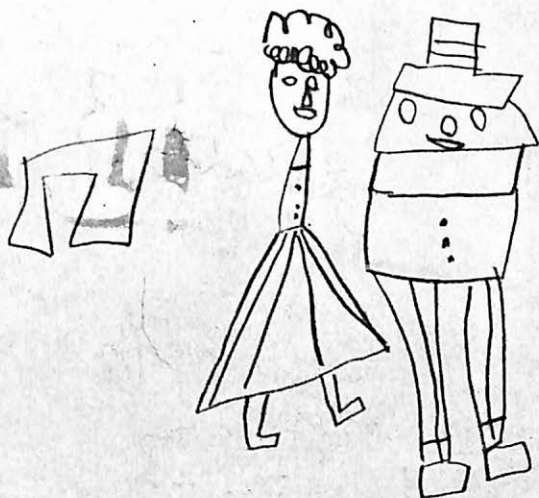


Figure 28

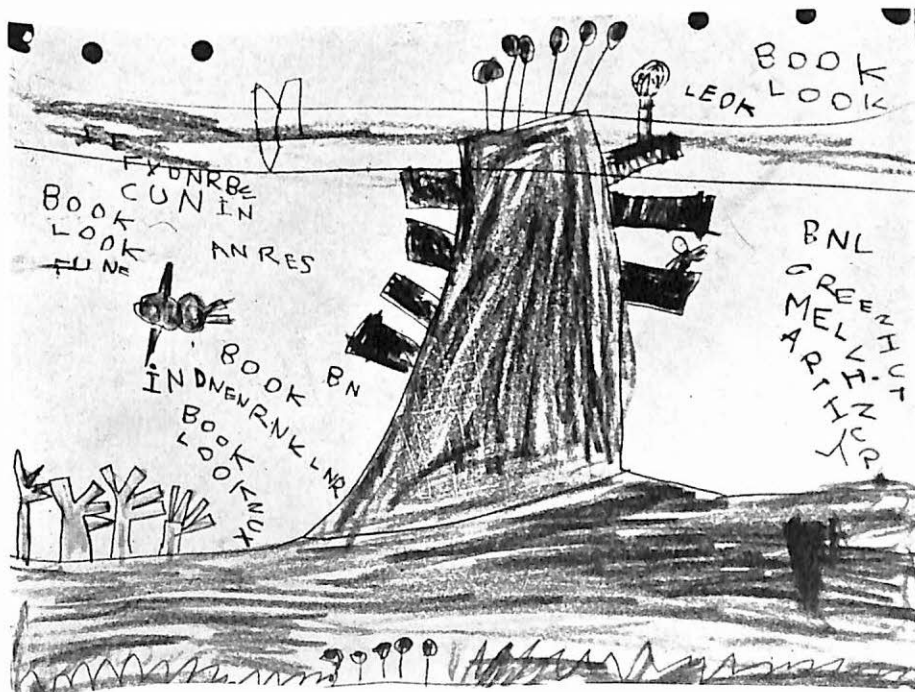


Figure 29

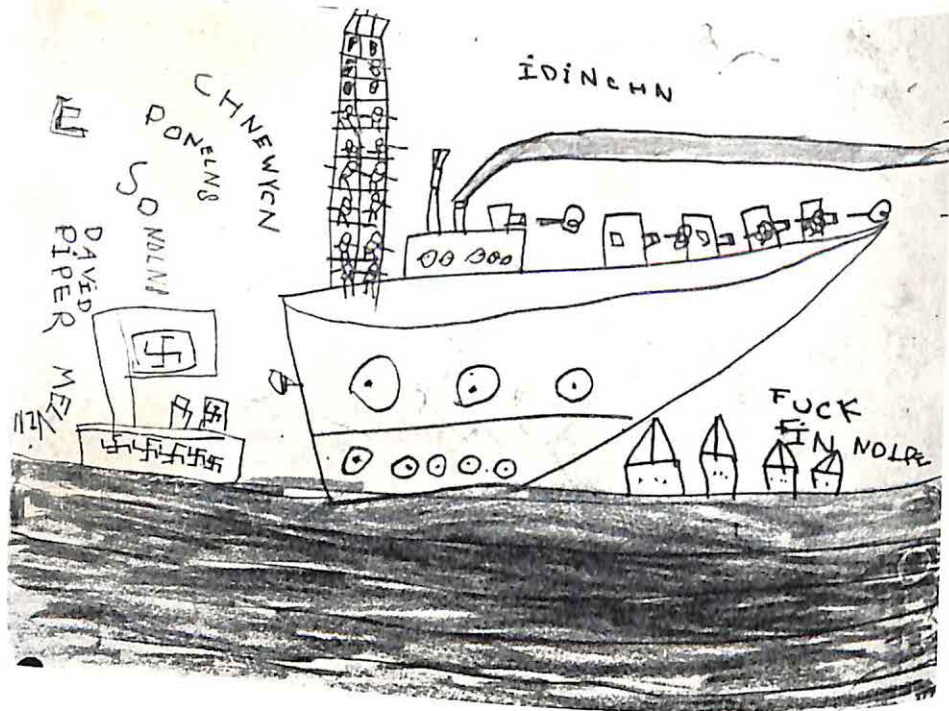


Figure 30

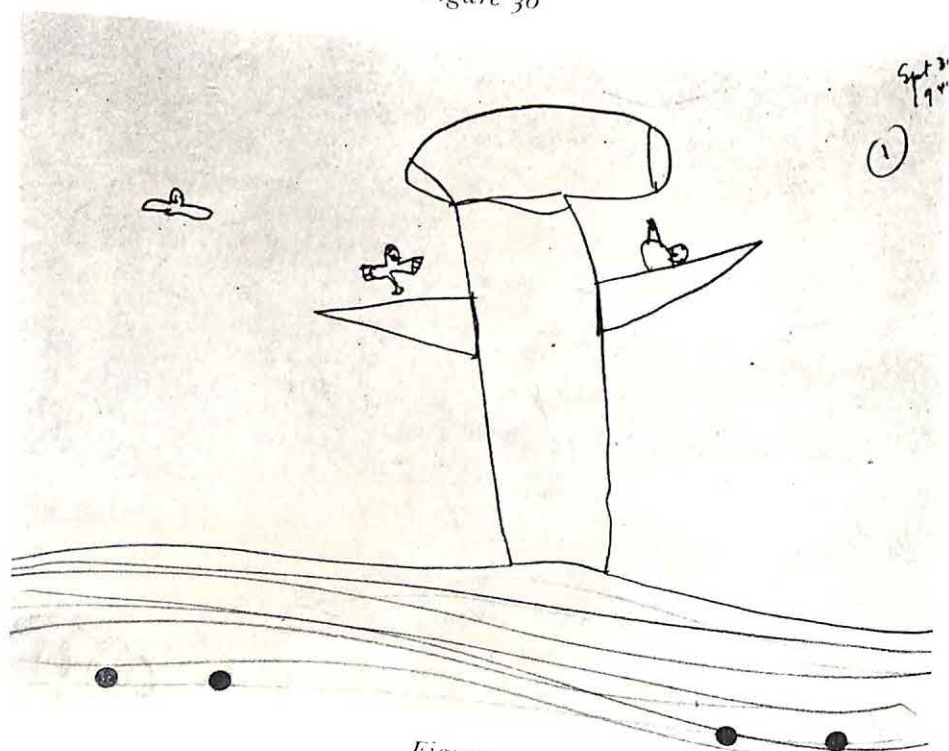


Figure 31

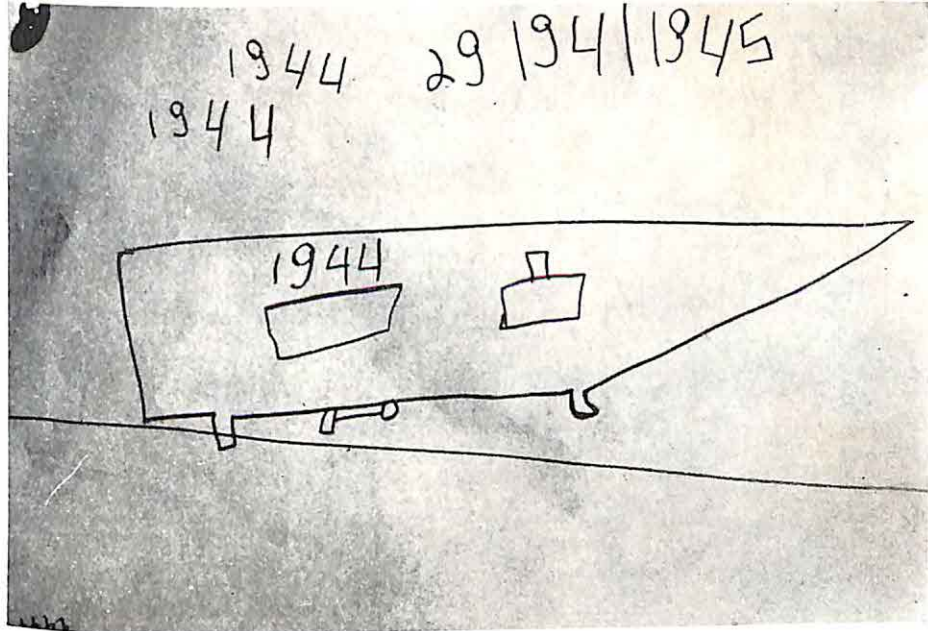


Figure 32



Figure 33

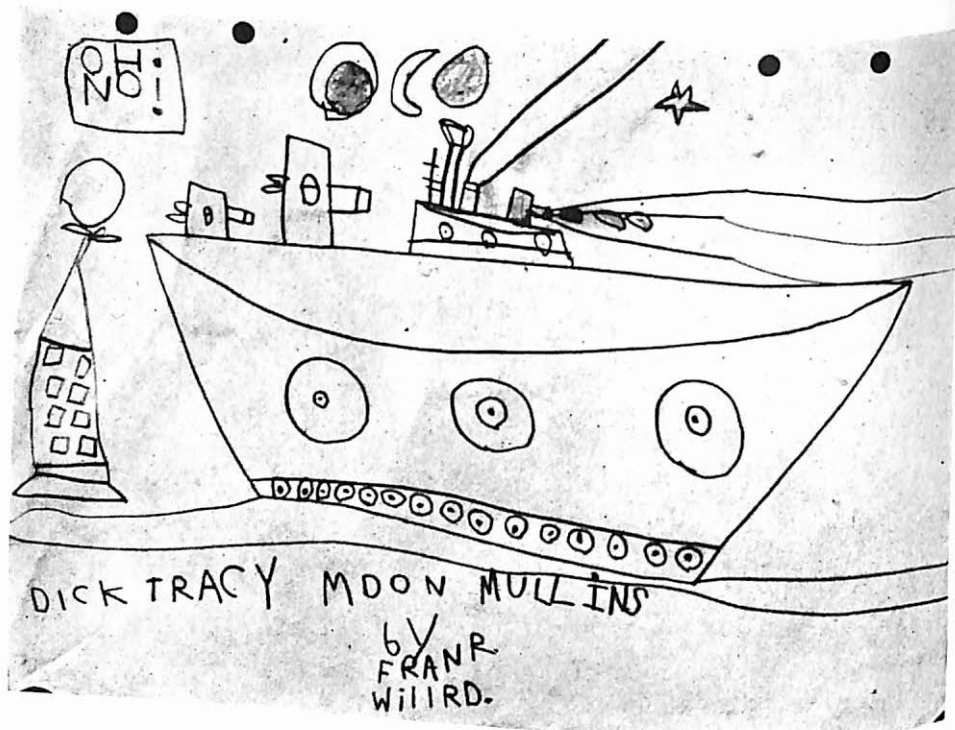


Figure 34



Figure 35

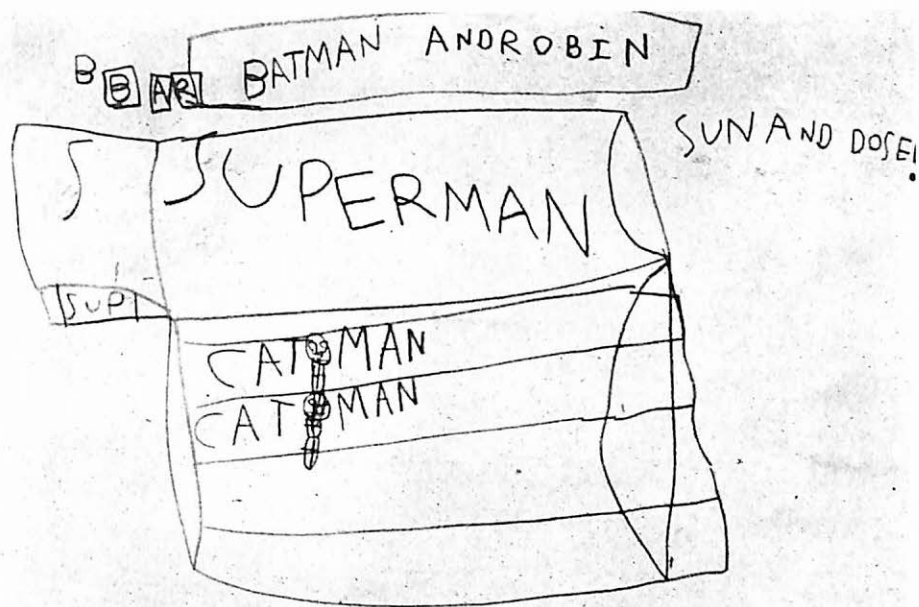


Figure 36

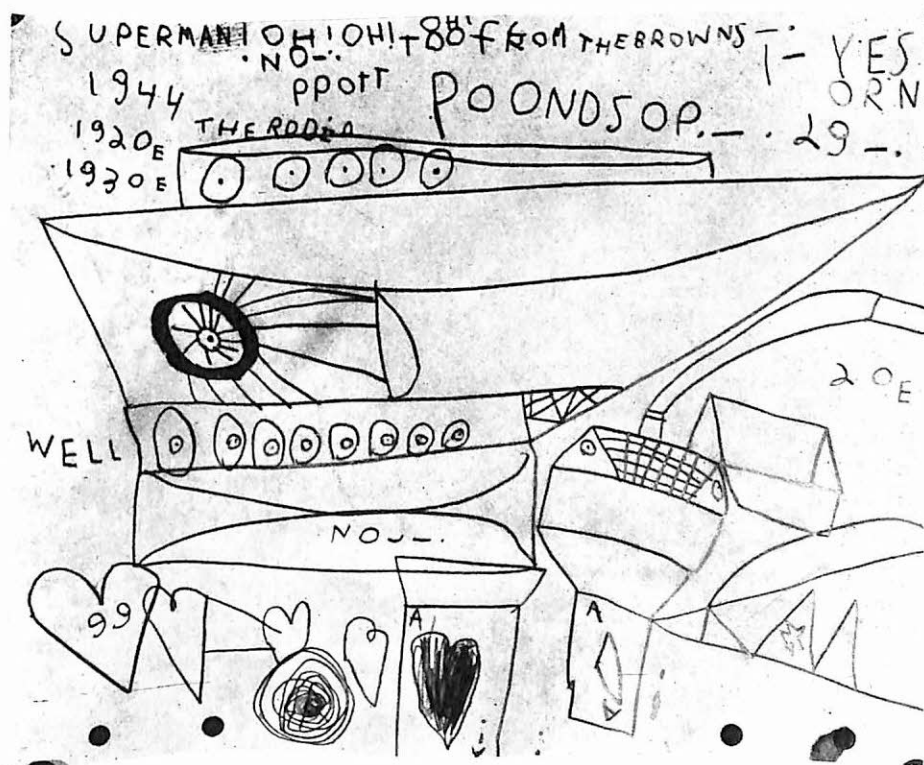


Figure 37



Figure 38

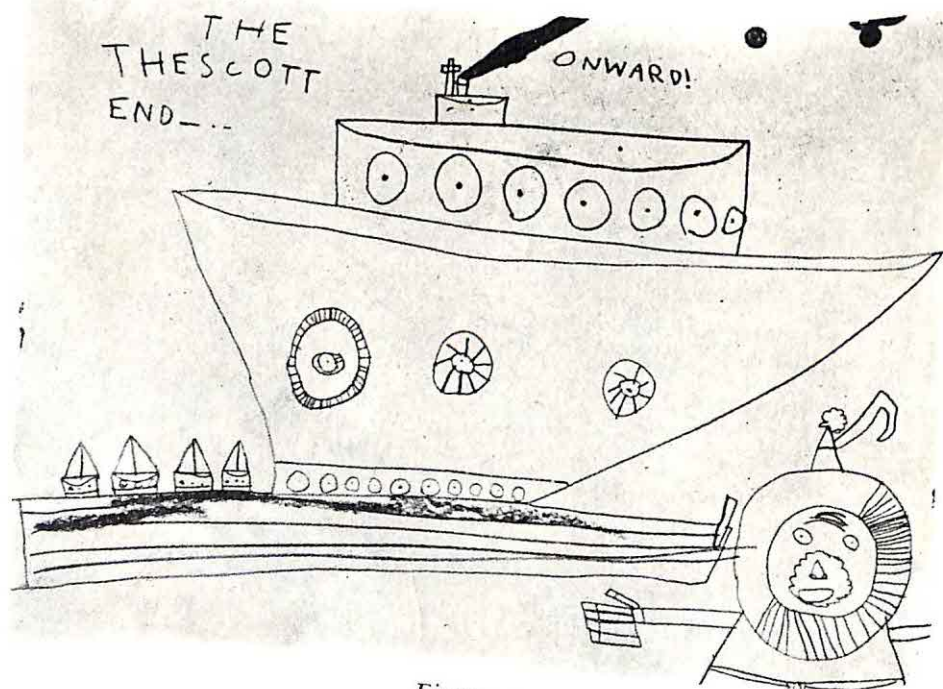


Figure 39

DO NOT TOUCH

WARD
WORK

MONDAY
MON
LAST
JOB
DAY

MONDAY
TUESDAY
WEDNESDAY
THURSDAY
FRIDAY
SATURDAY
SUNDAY

GOODNESS
GOODWORK

Figure 40



Figure 41

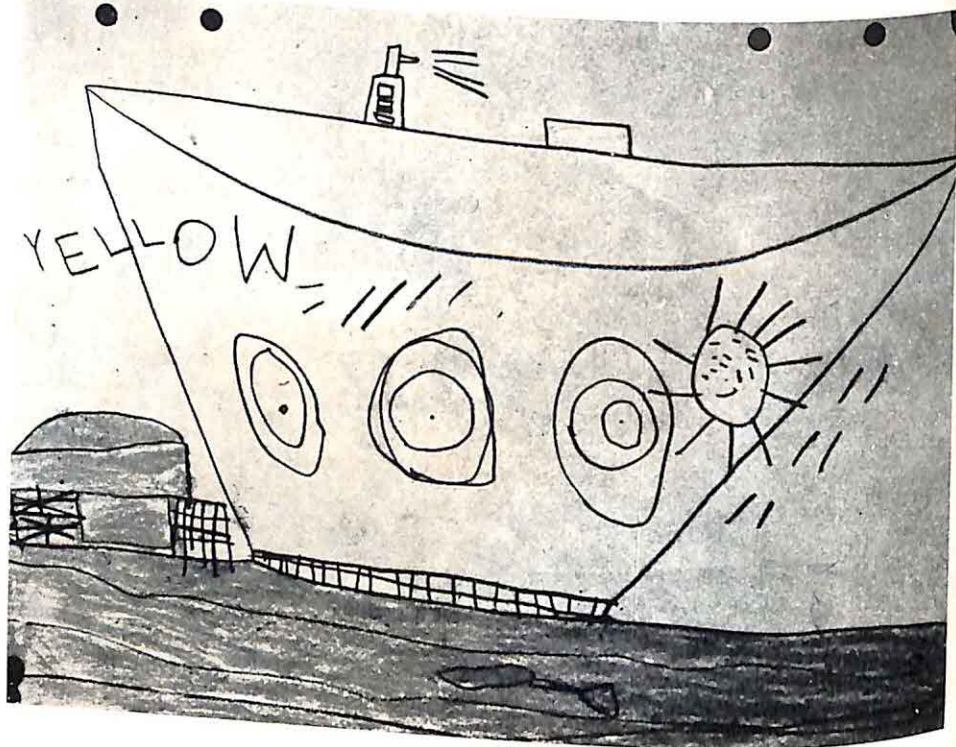


Figure 42

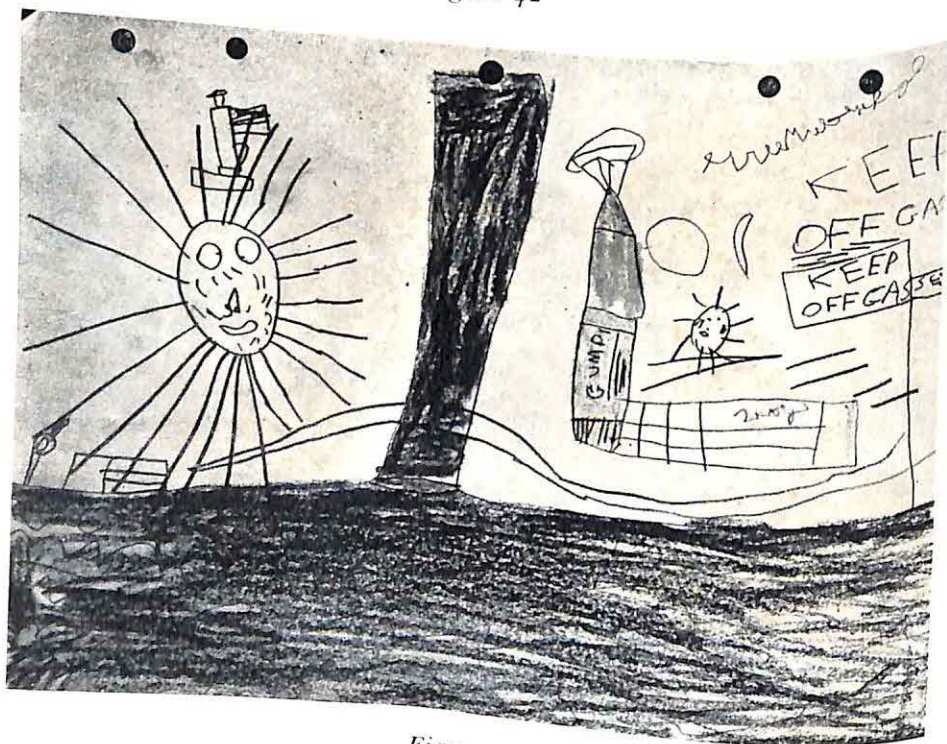


Figure 43

day they are able to hold an implement. It has been repeatedly emphasized that the expressive force of primitive child drawing follows the line of primitive adult art. We vainly strive for such qualities in modern art. While children's art is acknowledged to have some of these "primitive" qualities, they are not similar to those which we consider valuable in our adult art; the two sets of values do not match.

This makes it clear that we cannot find by this way a methodological basis of evaluation in the field of juvenile art research. It is equally difficult, even in comparing the products of a living individual with those of a culture dating back at least six hundred years, to apply any of the anthropological and historical methods which have been developed for the study of primitive forms of language. This is because we are not dealing with a formal expression but with a kind of religious symbolism which, as such, has never been studied in such a way that its content was made the central object of investigation.

This explanation is necessary in order to eliminate the misunderstandings which quite naturally arise if juvenile art works are offered as a medium of psychological or educational studies. For our purpose it is unessential whether these drawings are made by a child of five, ten, or fifteen years of age, whether the child is of Negro, Jewish, or British descent, or whether his capacity for formal expression corresponds with his natural age. We are mainly interested in the content of his experience and the unusual products he creates. We are also interested in what goes on in his mind regarding this content during our work with him. Although in the preceding case report the boy developed a simpler and clearer presentation, these formal elements are not the object of our study; they are secondary characteristics.

We should not have been obliged to eliminate all possible formalistic considerations if we had not feared that the essential problems of our case would be misunderstood. We can find a methodological starting point in C. G. Jung's work (116) on collective subconscious symbolism. Almost four decades ago, Jung attempted a psychological study of the processes involved in our use of symbolic expressions for the kind of experiences for which

we have "no words." His attempts at a psychology of the symbolic picture language which is found in any period of human development and in any national group have been very little understood and less acknowledged. His psychology of symbolism centers in his explanation that it is that part of our inner life which lies below the surface and which never comes to the knowledge of our consciousness and our rational and intellectual experience, and which we now call our subconsciousness, makes various use of symbolic language as its actual form of expression. In this respect symbolism is the language of the nonrational sphere of our inner life. Jung's achievements along these lines afford a methodological key to the understanding of the means of symbolic expression of the demented boy in our case report and of the amazing fact that he reproduced and actually lived with a symbolism typical of the religious experience and expression of the European Middle Ages.

THE SYMBOLISM OF SUBCONSCIOUS COLLECTIVISM AND MYTHOLOGICAL CONSCIOUSNESS

From a more radical standpoint it may be said that any expression of man has symbolic character; in other words, it expresses something beyond what it is itself. A distinction has sometimes been made between symbolic and rational language, but the means of expression of rational language are basically symbolic. Certain letters represent certain sounds which are produced by a phonetic mechanism and from these letters are formed words which stand for facts or relationships in our experience. During the antisymbolic period of the last century there was a general demand that we should limit ourselves to these few, rather meager symbols, but this period has taught us the need for certain experiences beyond this kind of symbol and that others can make it easier for us to understand even complicated facts, some of which cannot be put into words even by modern scientific methods. Even in the field of modern natural science there has developed a symbolic language, called "pictography," which enables us to grasp at one glance a complicated statistical complex. Entire scientific theories are presented in pictorial form which otherwise would require long descriptions. All these could, how-

ever, be described by words and intellectual expressions. Many human factors cannot possibly be expressed by intellectual means and for these we have invented nonintellectual, generally pictorial, forms of expression. Emotions, desires, etc. are nonintellectual forms of our inner life which find their expression in this way, especially insofar as they are means of communication and expressions of collective connections. We would not have a flag if a group had not wanted to express by this means the unity of its members. We know how many signs are in use for religious and secret societies and for all the occasions where it is not desired to rationalize things and make them understandable to outsiders. Examples are the secret symbolic languages used by Freemasons and by members of certain churches; here symbols have their very real function and rôle.

The intellectual language composed of signs and words is a rather recent development in the history of mankind. Not much more than 2000 years ago man reached this stage of communication. Primitive man expressed himself entirely by means of symbols. Even up to the seventeenth century the principal expression for the more refined and complicated facts of man's experience was the symbolic, pictorial form of expression. The cross, for instance, not only has been of profound significance to the entire Christian community throughout the 2000 years of its existence but can be found many thousands of years earlier as the expression of similar symbolic content. Symbols like the circle, connected with sun symbolism, and other simple mathematical forms have become laden with symbolic meaning. The most interesting with regard to these symbolic signs is that they retain their symbolic meaning over long periods of human history, becoming a part of the cultural hereditary realities of human existence. They become, as someone has said, a part of the experience of every human experience like the ability to walk. Whatever any member of Western civilization may personally think about the cross it means "something" to him. This is the best explanation of the collective reality of any symbol: not only can it be used as a means of communication but in addition it has a definite independent meaning for every individual. This separate meaning, however, is common to a more

or less large group of individuals on the one hand; on the other, it is not an intellectual meaning which could easily be expressed by words. We might even speak of a *general "symbolic sense"* in almost all human beings which seems to be as old as the communication between men and which without doubt is older than any intellectual intercourse by means of words. Considered in this light, symbols are elementary "signals."

Those who have made a deeper study of human mental development and with it the capacity for learning have been profoundly impressed by the fact that a human being learns fastest during the early period of life. If we compare the amount a baby has to learn during his first three years in order to absorb all the factors necessary in our complicated modern existence, we could say without exaggeration that it is fifty times as much as that acquired by a young person during the following ten years of academic school training and a hundred times as much as that of the average adult in later life. Students of such problems, including heredity, have not yet found the key in defining it merely as a "capacity for learning." Human babies have actually to learn certain capabilities which are the inherited birthright of the lower animals. But the human has accomplished the basic change from lower to higher capacities which enables him to walk upright and develop the mental capacities inherent in his larger brain. Investigation of inherited abilities in animals have uncovered similar factors in human life. A child cannot be said to "learn" to smile; he begins this elementary expression of human social intercourse of his own accord as soon as he is old enough to express himself in this way. Along the same line lie all those faculties of apperception and comprehension which astonish us in children. When a child is asked, "Where did you learn this?" he often actually does not know. This capacity for reasoning and comprehension cannot be called merely "learning capability"; it is actually an inherited knowledge pattern.

We may then infer a relationship between preintellectual symbolic expressions and forms of communication and such a hereditary pattern. Such symbolic expressions existed long before the beginning of intellectual intercourse by rational words;

they are far more aboriginal and prehistoric. Studies of children's art have shown the tendency of their formal expression to symbolic contents of which they do not know the meaning. Children not only draw before they can write and talk intelligibly, their use of symbols is identical with the real symbol languages. The child has inherited the ability to use this language which has always been spoken by mankind. But not until modern depth psychology began to study these facts was it understood. Depth psychology has also made us aware how little any expressions of a small child, especially below the age of three, can be evaluated individually and how much they belong to general human character or to the character of the group in which the child is raised; both, of course, are of collective character. Every child has a mother and a father and knows this "collectively." Many other things belong to the wider sphere of a child's experience which he is still unable to comprehend clearly or in words and which have the same background. We now know the meaning of subconsciousness and how much of a child's early life is determined by his inner experience.

Children often say amazing things about God and the ultimate great things of life, and parents believe their children must be prodigies to utter expressions which sound so like the language of religious documents. But actually almost all children produce such sayings, which are the most characteristic products of the inherited pattern of experience and appear in an undiluted form in children because they have been as yet little influenced by a wider experience of life. The subconscious produces such expressions in the same way as it uses the language of formal symbolism which it is not yet able to verbalize. But such facts have a still more far-reaching importance. In a recent paper on religious experiences in children (86) I pointed out that children reproduce images of religious experience which were common hundreds of years ago and in far-distant cultures. Investigation proved that these children had had no contact with the present sources of such religions. This shows the tendency of children to reproduce hereditary symbolic patterns. It is probable that one out of ten children produces such elements either from strange cultural worlds or religious spheres of which it has not

learned the real meaning by any intellectual instruction. The case reported here is an example of such a reproduction of religious elements which did not derive from any intellectual source. His sphere of symbolism has already been designated as medieval alchemy.

To approach this concept of alchemy objectively, in order to consider its rôle in our problem, we must first realize that it was *not* an abstruse mysticism followed by eccentric minds in the Middle Ages. It was, on the contrary, a conception followed by the greatest minds of the fourteenth and fifteenth centuries. The finest works of art of that time, for instance those of Dürer, Leonardo, and Michelangelo, reveal the pictorial application of such concepts, and the writings on natural science, philosophy, and religion also have as basic concepts some kind of alchemical or cosmo-chemical philosophy which was then the most characteristic pattern. These survive today only in the decadent form of astrology.

Our lives are still basically affected by the sun; we count the cycle of the year from phases of the moon; we have astronomical evidence that sun spots profoundly influence life on this earth. At the time when alchemy flourished, people believed in an entire system of such astrophysical beams coming from other planets and basically influencing our life on earth. Never has a more detailed and complicated system of natural relationships been constructed; compared with it our chemistry seems child's play. There were planets and constellations related to every part of the body, every type of character, any plant or animal, or other natural and historical events. The earth was more or less a mirror of the cosmos, and our lives a product of the actions of the stars. In this cosmo-chemistry sun and moon played the central rôle and were the basis for most of the important events of human life. They had even a certain moral function and were connected with the inner development of the human mind and soul. Such development was a central feature of the deeply religious Middle Ages. To overcome physical sin and to live a saintly existence was the principal object of the mental pattern of that time. Woven into this pattern was the relationship to the cosmos. The sun was the light, good, purifying power of the cos-

mos, while the moon represented the dead, materialistic, morally unclean part of existence as well as the evil forces of sex. The Virgin Mary is depicted as standing on the crescent moon in overcoming the moon forces in the immaculate conception. It was a main cosmic-alchemic theme that the sun must overcome the evil powers of the moon by fertilizing it and absorbing it into the reality of the sun. The sun-moon impregnation is portrayed in thousands of symbolic pictures in every alchemical book. It is a basic process which constantly recurs in the various stages of cosmo-chemical or alchemical procedures and descriptions of natural events. This brief explanation should suffice for an explanation of our present psychopathological and psychotherapeutic problems.

ATTEMPT AT AN INTERPRETATION OF THE PATHOLOGICAL STATUS OF OUR CASE

The present interpretation is not a theoretical concept which could be applied to cases of a similar type. It is a pioneering voyage toward almost undiscovered countries. I hope that other workers will look for similar cases and make their own interpretations. If results similar to mine should be found and my interpretation should be confirmed, this alone would give them a general theoretical importance.

To recapitulate briefly, our case was that of a preadolescent boy, in a state of amentia, unable to speak or write as well as he had before his illness became severe. He was uncontrollably restless and had a severe primary behavior disorder. In his first attempts to draw, he produced primitive symbols, such as a flag, etc. When we created a release situation he drew first a medley of confused reminiscences, the major features of which were a long form, which he called "he" and a rhombic one which he called "she." Later, when severe attacks of excitement had been overcome, he drew a clear image of a medieval symbolic drawing of an intercourse scene between sun and moon.

There can be no doubt of the relationship in his mind, or rather in his subconscious, between loss of mental abilities and restlessness on the one hand and, on the other the urge to express himself by means of a pre-intellectual symbolic picture lan-

guage. Since our present psychopathological terminology has no designation other than obsession, it may be well to take a word from the language of the time from which the boy derived his mental pattern. In the Middle Ages, if a person showed signs of not "being himself" or not in "possession of his own mind," he was called "possessed." This boy, in his restlessness and with his obsession to express symbols, can best be described as possessed by this urge. This possessedness was so strong as to eliminate or overtake all his intellectual functions. This elimination of the mental capacities proved to be temporary, since they returned to the level on which they had functioned before his illness once the disabling obstacles were removed. The severity of his mental disablement may be judged by the fact that he did not call himself "I," using his first name instead. He had regressed to the mental pattern of a baby before the development of the ego. The first time he used "I" was when he identified his first alchemical drawing. In a very real sense he had been pushed back to an "egoless" stage in which he had to seek the language of collective expression, which we have given in symbolism.

We shall make no attempt to discuss the causes of this stage of mind for we have no means of determining them. In a case like this, where we must overstep the border of the present methods of scientific interpretation, we must avoid any excursions into fields where we lack understanding. However, when a preadolescent boy in a state of "egolessness" feels impelled to express himself in a predominantly sexual collective pattern, the explanation may lie in his approaching maturity and his preoccupation with these facts. All mental defectives have a similar tendency which frequently is connected with permanent mental infantilism. Our patient also tended to express his few remaining intellectual or semi-intellectual activities in the crudest sex language and continued to do so even during the course of our collaboration. However, this sex language was not related to a concrete understanding of the sexual functions but was merely an inherited knowledge of the elements of sex, as shown by the two basic forms which recurred repeatedly as the center of his imaginative expressions. Some may call such sex knowledge "instinctive"; I prefer to call it "hereditary," which I believe

does not contradict the idea of instinct since this must also be hereditary.

There is no doubt that the sun-moon relationship drawn by the boy falls into the class of phallic and vaginal symbols of hereditary sex imagination. But *why* he produced these alchemical symbols and no others we are unable to explain except by the simple statement that he had just this hereditary connection and disposition. Some children reproduce various religious concepts and we have no better explanation for this than for why adults choose any particular religion or philosophy. Our patient simply had a tendency or disposition to these alchemical concepts as a hereditary feature of his personality.

This disposition undoubtedly supplied the background for his mental disorder. If he had been a fairly normal boy he would have played with a chemistry set or joined a junior astronomer's club and made weekly visits to the Planetarium. . . . However, even today when we believe ourselves to be guided mainly by scientific ideas in our main approach to life, many people still have a religious or semireligious attitude toward such astronomic and cosmic factors. Many of the great religions are full of such astrological beliefs. Jung has shown how much of the imaginative elements and symbolisms from both new and old religions inhabit our subconscious and play a fundamental rôle in our reaction to various cultural patterns. Each one of us carries within himself such inherited elements and in many of us they act as a sound basis for our relations to various cultural patterns and their formal traditions. In neurotics they become troublesome if they assume an obsessive form in contradiction to that imposed by their lives, or as incomprehensible contents of day or night dreams. Neurotic persons may suffer severely under such conditions, especially if they are of a religious nature and unable to settle their religious problems.

One more aspect of this case remains to be discussed and it is the one most difficult to understand. How could this medieval imagery appear in such a perfectly clear and complete form in the mind of this demented child? Most products of the demented, the half-mad, and even of the fairly normal who draw such symbols, are distorted or fragmentary. We can only sup-

pose that he had become so little involved in real mental life that he had become a pure transmitter for such hereditary symbolism. This unusual case gives us a real opportunity for insight into the appearance of subconscious hereditary elements.

THE THERAPEUTIC PROCESS

In our psychopathological report we declined to give any theoretical aspects and we emphasize this still more strongly in our interpretation of the definite improvement and change in attitude of our patient during the period we worked with him. While there is no doubt that our influence upon him was of a therapeutic character, it was not intended in the usual sense as a definite cure. It was more or less an experiment carefully carried out to be sure that the patient's condition would get no worse. We simply wanted to discover what a simple release by means of drawing would accomplish in a demented child who evidently had an obsessive desire to express himself in a pictorial form.

After we had, in this simple way, set the scene for a release, our object was to see whether such release methods would simply diagnostic as well as therapeutic procedures. When we realized that it was a case of hereditary symbolism, we applied the knowledge we had acquired from a study of Jung's viewpoints and methods. Most of the material presented here is the author's own opinion and, as said before, he regards it more as a venture in pioneering than an attempt to set up standards.

The basis of a therapeutic approach to such a case is an understanding of the medieval or ancient concept of which the symbol is the expression and a knowledge of the psychological role played by symbolism, and the dynamics which are the basis of this entire concept. It was clear from the beginning that the boy must be given the opportunity to live out the relationship with this symbolism and to express it with absolute freedom. As has been mentioned before, whenever the sun-moon relationship occupies the middle place of the concept, it represents the fertilizing of the moon by the sun and the eventual victory of the sun forces over those of the moon. This aspect had to be

carefully watched and represented the chief part of the attempt to free the boy from his obsession.

The first step was to test the reality of the concept in the boy's mentality and the various angles of the problem. The results of the tests showed that this symbolism was a very real factor in his mentality and subconscious. One of his earliest drawings (see figure 28) proved that he had only a symbolical understanding of the sex processes; they were only a "symbolic concept of hereditary pattern" to him. His mind became clearer almost immediately after a therapeutic situation in regard to this symbolic process was established.

This therapeutic situation had to be established according to the medieval concepts of such obsessive factors. A study of such concepts reveals that a drawing of a symbol calls forth the subconscious forces concerned. Since the boy was evidently an individual of this medieval mentality this method was applied, not by giving the boy a general drawing of the sun-moon symbolism but by showing him *his own* concept. This assured me that I remained within the circle of his own concept, but it also called for his own ego and consciousness. During all of the following exercises his own drawing was held before him. The most important element in the entire therapeutic procedure was that he subconsciously realized that I understood him and his problems. Of course, during the first eight or ten sessions nothing occurred that could be described as intellectual or conscious understanding by the boy of his problem such as doubtless developed during the later period of our collaboration. His reply of "You know" to my question of what the symbol meant was evidence of his subconscious knowledge that I understood him and his resistance to my repeatedly showing him his drawings was evidence of the inner struggle with the obsessive forces to becoming conscious and of the release of those vectors of the psyche which they had completely overpowered.

This method of making the symbolism conscious was amazingly successful. The ability to write and think and count slowly returned. The drawings themselves became simpler and more organized even after the intermission of my summer vacation. In

continuing my treatment for the release of his consciousness from its medieval symbolic imprisonment I carefully followed the technique of demanding more and more conscious and thinking activity. However, I adjusted myself as much as possible to the momentary status of the boy's mind. For instance, I never mentioned the real meaning of the drawing of the sun and moon until he himself stated that it was the sun and moon. From that time I spoke of them repeatedly, although I never mentioned the esoteric meaning of the symbolic relationship which was an "understood" factor between me and his subconscious. *This kind of "esoteric" behavior seems to me essential in all such therapeutic procedures.* They all move in a sphere of "tabu" which must be maintained if the therapy is to succeed. Children's minds are not ready and often not willing to intellectualize and such methods often do considerable harm. On the other hand, they react naturally to a symbolic approach in tabu form.

There is, of course, a difference between the general tabu situation and one where the object is to free a consciousness from being overpowered by such subconscious symbolic tabu elements as was the case in our patient. His was a case of "historic backwardness" which threatened to overpower the small modern consciousness which he had been able to develop. Therefore I had to fight these symbolic elements by eliminating them altogether. This I accomplished by allowing it to work itself out in its own pattern and at the same time assimilating it to a conscious intellectual pattern by talking about it.

We already know the result. The boy underwent an "alchemistic transformation" of the moon forces into sun forces in his consciousness. Finally he drew the powerful sun and even signed his name symbolically as a sun. But after I had helped him to work out this "alchemistic transformation," what emerged was a reawakened modern consciousness as it had been before his mind had become darkened.

X

AUTOGENIC THERAPY

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THE NAME OF J. H. Schultz, Professor of Psychiatry at the University of Berlin, and his theory of autogenic training, are almost completely unknown in this country (163, 164, 165). Problems pertaining to how much and how far the adult as well as the young mental patient can or ought to participate or be made to participate in his own cure have never been discussed by American psychotherapists. It seems as if the possibility of such a problem has not as yet occurred to anyone in this country. Therefore, before I can expect to be understood, it is necessary for the reader to understand the basic problems of self-healing in general. And, since we are concerned primarily with children, we will consider its application to therapy with certain groups of children.

I have always opposed the general and undifferentiated transposition to work with children of diagnostic and therapeutic techniques which have been successful with adults. However, the technique of autogenic training must be reviewed in its development with adults before one can expect to be able to make use of it with young patients. One of the most general assumptions in our present treatment of mental illness is that the influence of a therapeutic agent depends on the cooperation of the patient and his participation in the attempts being made to help him. When we find a lack of this participation, we feel unable to apply our psychotherapeutic efforts. Simply stated, we know that the patient must want to receive help. On this level, of course, the major emphasis and effort of the curative action still rests with the

therapist. The cooperation of the patient may be only that he does not resist or offers what may be defined as a passive acceptance to the activity which the therapist applies to him. This is what occurs in many cases of therapy.

Real self-healing is of quite a different pattern and, particularly, there is a completely different relationship between the patient and the therapist. The patient becomes the center of this relationship, and the therapist continually moves to a more secondary rôle, assuming an assistant or advisory function. Although we have spoken above only of self-therapy, there has also been developed some form of greater participation of the patient in diagnostic work.

The diagnostic aspect of self-help is primarily known in the form of *self-analysis*. One of the basic contributions that the Freudian psychoanalysis has made to psychology is the clarification of the factor of resistance to insight into certain abnormal forms of behavior. It has at the same time inaugurated the organized form of self-diagnosis in combination with therapy which psychoanalysis actually represents. Self-analysis, as it is advocated even by Freud himself in his later years, lends itself only to a diagnosis in the limits within which psychic self-observation is able to move. A major portion of the material the diagnostician receives when interviewing his patient is based on such self-observation. Beyond that, self-diagnosis depends on the ability of the patient to understand his actions and his total behavior. Self-interpretation is an almost automatic reaction, at least in the adult. We know that in the mentally deranged as well as in a good many healthy people, these self-interpretations are painted by the individual's pathology. We know, too, that these interpretations or misinterpretations can become the most stubborn factors of resistance against reality and true interpretation. The worst of these are those which result from the reading of psychiatric literature. If anyone is skeptical about self-diagnosis and self-interpretation, even in the form accepted by the analyst, it is this author. The contribution which the patient can make to his own cure is primarily in terms of therapy. Diagnosis is always a job requiring the objective approach of a professional worker.

All of this is more particularly true in work with children. We know that it is always difficult to get reliable information from a child by direct questioning and that usually a variety of ways closer to the child's usual behavior such as play activity and drawing provide more reliable information about problems and pathological behavior. In the chapters on "Child Art As Diagnostic Means" and "Transitional Therapy" I presented some of my own efforts in this field. It seems to me that in my presentation in the chapter on child art diagnosis, I have gone much further into depth analysis and extended self-diagnosis than has previously been attempted. However, it is still not completely justifiable to speak of these attempts as self-diagnosis. Indeed, it is my opinion that we cannot achieve anything which can be called valuable self-diagnosis in any patient before adolescence.

The problem of therapy is quite different. In general we state that the individual's participation in his own therapy actively improves his mental status. There has been a great deal written about the way in which the therapist may cure the patient. However, there has been little systematic survey of how the patient can contribute to his own cure, although some use of the patient's participation is made by practically every therapist. When the therapist advises a patient "to do" or "not to do" a particular activity, this is actually an aspect of self-therapy, because the patient himself undertakes the activity even though it may be under the influence of our advice. Beyond this most elementary approach we have others which require still more patient participation, such as occupational therapy. We use the same means of self-activity to redevelop interests and social relations in the patient which tend to lead to a better understanding in solving their problems. However, these are still what one can only call secondary forms of self-therapy. Actually direct self-therapy starts when the patient takes his cure in his own hands and the therapist assumes a kind of secondary function of merely directing, supervising, and guiding. With the exception of the conservative Freudian school, there are quite a number of present-day psychotherapies which in some form utilize some degree of self-therapy. Some have developed a very specific kind. Jung, for instance, uses painting and reflective writing (117, 184) to help

his patients clarify their conflicts (72). Others give their patients specific tasks, such as reviewing their problems and their ways of living. Some have even developed direct exercises in relaxation, concentration, or meditation; and others have gone so far as to present their patients with a definite plan for daily living. Although there is a variety of such methods used in present-day therapy, there is almost nothing in the literature which could be considered a systematic development of such techniques. The only fully developed method of self-therapy is that of J. H. Schultz, a relaxation method which he calls "autogenic training." While this method is most far-reaching in its attempt to put therapy in the hands of the patient, it is not our purpose to fully describe Dr. Schultz's methods, which have been carefully presented in his book (163). We can only point out that the basic principle is that by the use of intellectual powers the entire body is gradually brought under self-control by relaxation exercises. Essentially, relaxation involves strict self-control.

In entitling this chapter as I have, I have chosen what may seem to be a radical designation. I intend to discuss the scope of self-therapy with children, including this most radical form of autogenic training. As should be evident to everyone, self-therapy with children is more limited than with adults. Intellectual insight and command as well as the ability to understand suggestions are more limited in a child. There is no doubt that up until adolescence, therapy is primarily the task of the therapist. However, there is one other point to be made which is essential in all therapeutic work with children, namely, that the therapist has in the child an auxiliary assistant in the guise of the growth processes, physical as well as mental. With the exception of the early European child psychiatrists (21, 37, 54, 99, 152, 172), one of the few in this country who has recognized this factor is William A. White (182). Even if one contends that, in a child whose pathology is primarily hereditarily and constitutionally conditioned, these forces may also reflect pathology, still it must be acknowledged that they are a source of energy which may properly be directed so that they can serve as a force for growth. I have repeatedly heard child-therapists state that they prefer

working with children to working with adults because nature assists the child in therapy. This may be considered as basic self-therapy, even though it is impersonal.

Therapy in a child starts as we begin to change his habits. This can take place only after a child has grown to the point where he can be influenced by the outside world. There are very serious psychopathological symptoms found in very early childhood, like head banging and self-biting, which we might be able to control to a certain degree by outside means if self-therapy cannot take part. Self-therapy in the child does not operate through the intellect and reasoning as it does in the adult. Frequently we receive better cooperation and a real beginning of direct self-assistance in a retarded or psychotic child if we begin on the basis of emotional ties (145). Such factors are much stronger forces in psychotherapy than any intellectual communication. For example, in three-year-olds the influence of such thinking as "my mommy loves me more when I do not do this" becomes an agent of independent self-improvement. Of course, like everything in this field, it is dependent upon the individual conditioning and disposition of the child. With the development toward adolescence, there is an increase in the readiness to utilize intellectual functioning for therapy. However, particularly with this age group, self-therapy presents special features. Rarely in later life do we find intellectual command of such power in self-therapy as is possible in the adolescent (173). However, careful differentiation has to be made on the basis of the nature of the disease and particularly the distinction between neurotic states and true psychotic conditions. Any technique which stresses the power of the self is of great value in adolescence. This age group responds more readily to therapy than any other. In working with healthy adolescents one is most successful and really most helpful to them if one does not give direct orders but presents suggestions and advice which strengthen their ability to make their own decisions. With neurotic or even psychotic adolescents, we also achieve most effective results if we give them a pedagogically sound degree of freedom in their participation in their own therapy. This approach corresponds to the very na-

ture of adolescence and its specific psychological traits and, therefore, has the greatest hope of success. With the younger, school-age child, success is more likely if self-therapy is maintained on the "you and I" level, that is, there is the constant cooperative work with the therapist. This age group needs a leader. A therapist often has great success if a leadership relationship is established with the patient. This is more complicated than the pattern which is based on "for the sake of love" which is applied with younger children and which may even be successful on all age levels.

As to the problem of relaxation therapy, this whole area in relation to children is completely unexplored. When I asked a group of educators what relaxation could mean, their answer was that "relaxation could only mean put them to bed or to rest." This crude conception of what relaxation means certainly does not lead to real relaxation in children. There is no doubt that in children who by nature are in many respects more sensitive than adults, factors of emotional upset, worry, and fears play a considerable rôle. Against all these factors, so long as they have not taken on a definite pathological pattern, relaxation is the easiest and most successful therapy. Certainly one cannot tell the disturbed four-year-old to "please relax." One can by the use of drugs help a child return to more normal emotional behavior. Many children help themselves in such upsets by falling asleep. But there are too many cases where the child cannot fall asleep and where the upsets are carried over into sleep. Here we get the terrors of *pavor nocturnus*. In such instances relaxation is, without doubt, necessary. We have found, for example, that a certain kind of music played at bedtime, or at other times when a child needs assistance, can be most effective. The type of music most effective is modern music which demands a certain amount of concentration on the part of the listener. We found Debussy's "Clouds," Poulenc's Piano Concerto, Sibelius, and Delius most excellent for this purpose.

It is most difficult to help school-age children to relax. As with the smaller children, self-relaxation or even exercises hardly ever lead to success. Sometimes music may help, sometimes sing-

ing, and sometimes a story which is related to the personal problems of the child may stimulate relaxation. The best is emotional stimulation of the *paternus* and *materna* level.

Adolescents, however, are best handled on the self-therapy level. Relaxation, if properly explained, is something very real and desirable for the normal as well as the abnormal adolescent. We have used it with hundreds of children of this age. Dr. Schultz, according to his writings, has not used it with this age group, but he does report its successful use by some of his co-workers (163). We have to some extent eased and modified the original autogenic training method to make it more applicable to American use. After explaining the purpose and aim of the exercises, we ask the youngster to lie down on the office couch or on a bed and to remove all tension in the body starting with the head and working down to the feet. When complete relaxation is achieved, a similar direction for inner relaxation is given by suggesting relaxed, easy breathing. This leads to the usual remark by the patient that he now feels "quite calm inside." From this state of mind may be evoked an imaginary view of the place the patient likes to be when in a happy or relaxed mood. Some strongly religious young people almost automatically wish to say a prayer. A patient kept in this state from two to five minutes will find himself astonishingly calm and rested. One can use this as an occasional exercise or as a daily routine. When one can individualize such exercises and better adapt them to the need of the individual patient, they become more valuable. One should note that it is important that they are not made into a means of withdrawal. It is most helpful if it is undertaken as a means of rest from life—as a separate exercise to be executed with a certain degree of sincerity and intensity which of itself can be beneficial to the total mental life of the patient.

We have found this to be an excellent therapeutic tool not only in simple neurotic states but also in specific adolescent psychoses such as schizophrenia and severe depression. It often gives the best general basis for further treatment not only because it appeals to the mentality of adolescents but also because it is a technique they can understand and to which, therefore, they would be willing to give their full cooperation.

XI

SUBSTITUTION THERAPY; * DOGMATIC OR DIFFERENTIAL?

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WHEN WE SPEAK of "substitute parents," we mean persons who of their own free will assume the rôle of father and mother to children who have lost their own natural parents. In social-welfare technique this substitution treatment is a rather new practice. Communal care of orphans is an old thing, its history being long and uneventful. For centuries orphans have been placed in "orphan homes" under the supervision of teachers or caretakers of their own sex and regarded as only about one step higher in the social scale than "poorhouse" unfortunates (32). They carried through life the stigma of their early environment, which often caused an emotional laming in their personalities. Then came the period when it was felt that the only fair thing was to place these children in a familial environment, giving them some sort of parental relationship. Orphans, or children whose natural parents had abandoned them, were found homes with relatives or well-meaning people; but they were left

* In the early forties the well-known New York pediatricist Ira S. Wile suggested to the author the study of a reform of substitutional care of orphans, with the purpose of collecting material for a special issue of *The Nervous Child*. A research project was laid out and a number of sincere workers joined in the work. World War conditions, however, ended their collaboration and the author was left alone with a mass of material. After struggling with this unrelated material and the entire project for more than a year, the author, with the help of some of his younger collaborators, succeeded in shaping it into a paper which appeared in *The Nervous Child* and which is here reprinted in a revised form.

with the feeling, conscious or otherwise, that they were outsiders—boarding children. These orphans did receive a better social standing in this way; however, there was no mental and emotional compensation for their unfortunate fate. They still did not gain their right to a gay and carefree youth that would serve as a healthy introduction to an adult life of inner security and strength of character. At present we know something about the psychology of parent-and-child relationships and about the need to substitute them if they are lacking or if those that exist are disturbing to the child.

Freud, Adler, and Jung—the three masters of modern analytic and individual psychology—uncovering the problems of these parent-child relationships, have pointed out the social and psychologic pathology involved in them, and the necessity of therapeutic attention to these problems, which are typical of our present-day social pattern. It is not necessary to agree with Freud's theory of the Oedipus complex or Jung's theory of *animus* and *anima*; the presentation of these problems has been sufficient to stimulate a different attitude on the part of those who work with these unfortunate children and thus must deal with the problems they face when growing into adulthood out of their disadvantageous childhood situation. Without referring to the individual theories presented by the contributors to our symposium, I should like to report concisely those points we must mutually consider most important for successful therapeutic work with orphans.

In surveying the literature on social therapy as it applies to the orphan situation in general, we find that only a limited amount of work has been done in this field. The United States can take credit for having done the most. But the results have been for the most part dogmatic generalizations to the effect that substitute parenthood has or has not been successful. When the relationship has not turned out well, the reasons given have been for the most part sociologic, with no attempt made to study the psychologic causes for the maladjustment. Probably this has been due to the fact that the entire orphan problem has been studied more or less from the social-welfare angle only by practical social workers. Their thinking has been limited by the kind

of training given by the monopolized schools for social work, which creates little impulse to overstep the borders of a social-welfare horizon and to study such problems from a psychologic or even psychotherapeutic viewpoint. Despite the fact that we live in the age of psychology and psychotherapy, these two aspects of approach have been tragically neglected with regard to the orphan situation and parental substitution in particular.

In tackling this special task here, we must divide the psychotherapeutic basis of the parental substitution problem into two parts—first, the actual factors involved in the substitution situation and, second, the methodologic viewpoints in the substitution procedures.

ACTUAL BASIC FACTORS IN THE SUBSTITUTION SITUATION

In considering orphanhood we must differentiate between *total*, *half*, and *fictional* orphans, since in each of these situations different factors play a rôle and different therapeutic means must be applied.

Total orphanhood, of course, means that both parents have died. Half orphanhood means that one parent is dead, and fictional orphanhood represents that unusual state of circumstances in which one or both parents are unable to fulfill the usual parental obligations whether physical, social, or psychologic. Cases of fictional orphanhood occur in prolonged absence of one or both parents by reason of professional or business necessity, or when one of the parents is sentenced to imprisonment, or when break-up of a home, owing to separation or divorce, interrupts the parent-child relationship, and, finally, when children are boarded away from home because of desired opportunity of better education. We shall discuss these different forms in detail.

Whatever type of orphan the child may be, we must be aware of the fact that the situation varies according to the age of the child at the time it is orphaned. Often one hears it said that it is a lucky thing if the child has had his substitute parents so early in life that he has never been conscious of not having had his real parents. This is mostly immaterial. The child realizes his unnatural situation, whether consciously or not. Harry Bakwin's (12, 13) excellent study on the difference in health conditions

among infants reared in a hospital and those brought up in a home environment, proved this most conclusively. Actually the mother and father relationships are the primary and basic sociologic and social-psychologic factors in a child's earliest experiences. A second period in a child's life begins when to these most elementary social relationships there is added that of play relationship with siblings or other children. This added second relationship can strengthen but also weaken the first and has a fundamental influence upon the substitutional situation when we deal with adopted orphans. This second relationship, which may be called the companionship relation, exists throughout an individual's life, being, however, most influential in the period from the third to the twelfth year. At this point a third social relationship presents itself, that of sex compensation. This sex relationship becomes more and more important in the course of a human life, so that it mostly supersedes the two other fundamental social ties. It has a great influence, of course, also in regard to the substitutional relationship. Another social factor that has great influence upon a substitutional relationship is that of apprenticeship in either its professional, political, philosophic, or religious form. The symbolism of the Gospel is very apt here: "Who does not give up his family relations and follow me, will not gain entrance into heaven." There is still another relationship factor that we must be aware of—that between the sexes involving the different generations. Modern psychology has made us conscious of the fact that the relationship of a boy to his mother is vastly different from that to his father, and conversely in the case of a daughter. This problem is not only vital in total orphanhood; it is also very specific in the situation of the half-orphaned child. The Parsifal myth illustrates this point very aptly. We see in it the result of one-sided development of the personality of a boy when he has been brought up only by his mother. While a boy brought up in this way receives the negative pattern of demasculinization, a girl brought up solely by her father receives the negative pattern of a too strong feminization—factors which have to be taken into consideration in planning substitution.

METHODOLOGIC VIEWPOINTS IN SUBSTITUTIONAL PROCEDURES

1. *Total Orphanhood*

If we want to take a very realistic standpoint with regard to orphanhood and its abolition by aid of substitution, we must consider each orphan as a socially sick individual, with parental substitution as the social-therapeutic process that will cure this social disease. Thus we develop the most sound and timely understanding of the major problems involved in this situation and overcome all the pangs of conscience that beset us on either moral, sentimental, or economic grounds, since these were the original bases for solving the problem of orphanhood from the very start.

There is no doubt, as was said before, that even an infant without an obvious awareness of his orphanhood has a subconscious feeling that he has no natural parents. When analytic psychology advances more deeply in this sphere, there is no doubt that we shall find ample proof of this fact. Just now experiments are underway to investigate the fear sensitivities of infants in orphan asylums, and these will offer the first of the proofs of this kind. From the standpoint of therapeutic parent substitution our task should be to avoid, and if possible abolish altogether, mass care in asylums, replacing it wherever feasible with care by kind individuals willing and able to exercise the physical and especially also the emotional functions demanded of a real mother and father.

The actual psychologic problem of orphanhood is of no real importance to the orphan himself until he becomes really conscious of his disadvantage. This cannot happen until the child reaches the age of ego consciousness, which is approximately in the beginning of the fourth year of life. For the most part social workers have not noticed this fact. Since this is the same time as that at which the companionship relation starts to develop, the consciousness of being an orphan is socially always combined with the companionship experience. If an orphan can draw positive human relationships from the companionship sphere, the tragic experience of orphanhood is weakened in effect. But if

such positive companionship experience is not possible, the unsatisfied desire for it will increase the unhappiness of the orphanhood experience. In all foster placement of children above the age of four, it should be observed that we have not only a problem of parent substitution but that of companionship substitution too. Orphans over four should be placed in homes where they can benefit from the companionship of other children.

Up to the age of six, when the school environment is added to that of the home, all children have a primary dependence upon the mother, and this is especially true of orphans. It is widely believed that a teacher or clergyman can substitute for the father experience. This is not valid. Even if the influence of the father upon the children in our present city civilization is limited in time to hours, this influence is more intimate and more strongly connected with the home life than is an outside relationship like that of school. There should be a father influence available for any child even after the school influence has started.

Most of the work done on this problem of substitution, both theoretic and practical, has laid too much stress upon foster procedures and too little on the specific psychology of the orphan, who needs to have the abnormal factors of his orphanhood ironed out in both a social- and an individual-psychologic sense. I believe that it will be possible for us eventually to bring to light, by psychologic means, those factors that are the basis for the tie between mother and child, as well as those in the ties that bind all the various members of a family together—the relationships we popularly call "blood ties." Needless to say, up to the present no plausible answer has been found to this sphinxlike question. If we are radically realistic, we must confess that no real substitution for these blood ties exists and their lack will always be more or less experienced by any orphan. Despite the amount of research done to find a common denominator for the social psychopathology of uprootedness that is so characteristic of the orphan, no results have yet been achieved. In one orphan there will be a depression state, in another emotional imbalance or at least a strong disposition to it, and in others definite delinquent traits. The only characteristic one may underline as to be found in

nearly all is *insecurity*. Each child will have its own peculiar reactions to its orphan state, and this necessarily makes the task for us a rather difficult one.

However, it is not only this individualistic character of the specific psychopathology of orphans that makes dealing with them difficult; there are quite a number of other complications. It is believed that finding foster parents for an orphaned infant may by itself compensate completely for the natural parental ties or even eliminate the need for these. Those who have carefully followed such cases of substitution at infant age have had to observe that there is a lapse in such a child's development the moment he finds out that he is not living with his natural parents. Sometimes such "betrayed" orphans fall into a deep melancholic state, reiterating that they knew all the time that their foster parents were not their real ones. Sometimes they travel thousands of miles and even across oceans in order to trace their real parents and their ancestry. At the present time the writer has under his care an orphan who stemmed from a very mediocre environment and was adopted by a very superior family in earliest infancy. This orphan did not do very well in the expensive schools to which he was sent and got lost in the superior environment in which he was placed, developing rather disagreeable traits, some abnormal in character. However, when put into an environment more nearly comparable to that of his own heritage, a really happy individual developed who is now doing well. From this case, however, the generalization should not be made that orphans always must be placed in an environment actually similar to that in which they were born. Nevertheless, we should keep an open mind in regard to this point when dealing with them. It should suggest to us that we must have a still more alert eye in regard to the individual character of each orphan. In addition, we should learn from such cases that the opinion frequently held, that if a child is adopted early enough not to realize his orphanhood, he should not show any signs of abnormality deriving from it, is not quite correct. On the contrary, it is wise to let the child know his specific descent and allow him to work out his problems as well as possible.

It is an unfortunate belief that orphans should be as far as pos-

sible adapted to the new environment in which they are placed by adoption. Foster parents must be selected from among people who are willing to acknowledge the specific individual traits of the child they adopt and to allow him to develop along the lines of his own character, instead of foisting a personality and a life upon him. This, of course, makes the work of finding adequate foster parents an even more difficult task than it is in any case for the social worker. To make really good foster parents, the kindhearted people who offer substitution service must be carefully instructed and trained for their job if they are to make a success of it. This is especially important in view of the fact that often the impulse to adopt a child is not a kindhearted one; much too often it is rather an egotistic one. There are the sterile women who cannot have children of their own, the unmarried women who crave motherhood, the lonely people who want companionship and gaiety in their homes, and finally those who think they can get servants or other help cheaply by this means. All these people are completely unfit for foster parenthood and should not be allowed to become substitutes. It is precisely our social responsibility to make careful investigations in regard to the motives for adoption, so that we may be sure that foster children can grow to a sound adulthood. We must avoid adding to their first disadvantage, that of being orphans, the further mischance of being placed in an environment in which they cannot grow up to be valuable citizens. Only if they are not hampered by negative and unfortunate environmental factors, can they be saved from growing into socially queer or even difficult and not infrequently dangerous characters. *We must never forget as social workers that the substitution problem is not a problem of the foster parents but first of all a problem of the orphan.*

In considering the second or social sphere of orphanhood, i.e., companionship, we must proceed from another angle. Whereas we believe that in foster parenthood everything depends upon a frank and open attitude between parent and child, we feel that it is wiser to keep siblings and child associates from knowing that their companion is adopted. The Cinderella situation that is so frequent in cases in which a child is adopted into a family with other children, will in this way be mostly avoided. Since an

orphan always is and will remain a stranger in a family bound by natural blood ties, we must take pains not to aggravate this difficult condition.

Not much satisfactory research has as yet been done regarding the sexual attitudes and the adolescent development of orphans. Some casual observations point to a tendency to extremes—impulses either too violent or too controlled, too early or too late. Thorough investigations are urgently needed. Children orphaned at teen age and adolescent orphans have been observed to have a strong tendency to seek someone to be close to in preference to the foster parents. Many of the conflicts observed in orphans of this age arise out of a feeling of obligation toward the foster parents for what has been received or expected from them, and out of lack of a deeper love relationship to these substitutes. These adopted youngsters frequently become bitter, and hate develops where they have to take anything from these people who mean nothing inwardly to them and who do not understand them. The almost universal feeling among these children is a desire for independence. As in the case of all adolescents, and even more in that of orphaned adolescents, tolerance must be the keynote of guidance.

2. Half Orphanhood

While we had to come to the conclusion that for total orphanhood we have no perfect substitute, half orphanhood—the loss of only one of the parents—can be compensated almost completely. However, there is another angle to be considered with regard to the method of substitution in half orphanhood. In total orphanhood we seek to find a suitable environment for the child, as similar as possible to that which the child might have received by living with his natural parents. Half orphanhood needs only social-therapeutic assistance to overcome the one-sided influence of the remaining parent.

The loss of one parent creates an imbalance in a family. The remaining parent takes over the rôle of both parents and as a consequence there is a one-sided influence instead of the natural dual influence of mother and father. As mentioned before, this is very aptly demonstrated in the myth of Parsifal, who was father-

orphaned. The difficulties that arise from the arduous tasks of caring for a family singlehanded are a burden on the remaining parent that creates in the smaller children, especially if there are a number of them, mental imbalances that remain with them later on in life. Sometime in adolescence or later an interfamilial substitution occurs, a daughter taking on the mental rôle of wife to the widowed father or a son taking over the rôle of husband, assuming the traits of the dead parent. Such children develop peculiar traits and are often very unfortunate in the choice of a mate for themselves. Sometimes the attachment to the parent is so strong that it hinders any further relationship for either parent or child, because of the jealous possessive emotions engendered.

Careful substitution, with consideration especially to the different needs at various age levels, is mostly a secure way of solving the half-orphan problem. So much has been said about stepparents that there is no need to discuss further here those difficulties that arise from second marriages. So much social discussion has been given to this subject that automatically the remaining parent and the future spouse should realize that their first and most important task is the adjustment of the half-orphaned offspring of the previous union. It is not an easy thing to overcome the natural psychologic struggles that are engendered at such a time; an additional problem is the change of feeling that occurs when children are born of the second marriage. Very often much better care is given to half orphans when there is no remarriage. The child substitutes easily and transfers the deeper "blood tie" and subconscious demands from the living to the substitute parent. This occurs most easily when the substitute parent is a relative. At age levels below adolescence, female substitutes are more acceptable to both sexes than are "uncles." However, after puberty the famous "good uncle" is more easily substituted. A good female governess or even a capable "nanny" makes a better substitute than an old aunt.

In wartime, total orphanhood is as rare as in peacetime. War brings about half orphanhood as a great part of its toll. The specific characteristic of war orphanhood is a kind of curious preparedness in the preadolescent child for the fact that this misfortune may occur. We normal adults do not expect the loss of

a loved one, anticipating constantly the day he will not return. Children, with a peculiarly neurotic and pessimistic feeling, are inclined to a fear of permanent loss. This can be explained by the fact that the father is actually "lost" to the child, as far as his immediate life experience is concerned, at the moment of departure for war. Children who have had direct contact with war expect the loss of their male relatives even before there is any ground for such thoughts. M. H. Mercier (140), in describing the effects of the war situation of French children, reported this phenomenon, which has also been observed by many others.

During a war period, the severe emotional strain under which the entire population labors makes the substitution problem and its solution a much simpler one, since there arises in so many people the willingness to assist in the task. However, in the long run, it is much more difficult to find the necessary number of *perfect* substitutes for the number of war orphans. Since governmental agencies will have to take intensive part in this emergency task, a correspondingly better job will be done than the social agencies could do in peacetime.

3. *Fictional Orphanhood*

This is so frequent, occurring in every fifth or sixth family, that it is rarely recognized as a form of orphanhood. Nevertheless it is the most vexatious form of it.

Fictional orphanhood derives from the relationship that exists between parents and children where the children are separated from their parents and the latter do not act in their usual capacity. We have already mentioned characteristic forms of fictional orphanhood—occurring, for instance, when children are sent to boarding school or college; or when the parents for social or professional reasons are forced to live in other places at a distance from their children; or where, as occurs in England, it is fashionable to leave the entire care and education of children to governesses; or at the other extreme of the social scale, where children are taken from parents by reason of neglect or because the parents are in prison; or, lastly, when the child must be placed in a corrective institution.

In all these cases it is not death that interrupts the positive

and natural relationship between parents and children, but unusual social circumstances. Sometimes these rest on ambitions and positive reasons, but their results are negative. The outcome in many of these cases is estrangement. This often may have begun before the separation, but in any case it continues and grows with the length of the separation.

In only a few cases can the relationship between parents and children be effectively restored. The estrangement is there, whether it is due to the child's absence in an exclusive private school or to the parent's internment in prison. The need for some kind of substitution is there in either case, and the job must be done well so that the child will not become a disadvantaged human being.

In the case of natural orphanhood, our problem arises out of it *per se*. In the case of fictional orphanhood, it arises mostly from social and individual maladjustment. As a consequence there are no specific remedies for fictional orphanhood, as the parental task has not been taken away and we can only see to it that the estrangement does not become too strong. In fictional orphanhood the actual parent-child relationship is going on, if only in fantasy or imagination. When children are homesick, for instance, it is not only because they miss the home environment but also because they suffer to a great extent from an unsatisfactory substitution or from the lack of it. This is not very widely realized but it is important if we wish to have success in the education of these children.

In the case of delinquent children who must be institutionalized, the task is a most difficult one, since it is only through substitution that we can obtain any social or educational results. We must underline that in no other form of orphanhood is correct form of substitution as important as it is in the case of delinquent or mentally sick children. It must be confessed, however, that too little attention has been paid to the adaptation of the substitute parents to the actual needs of the socially and mentally abnormal child. As said before, foster parents must be carefully selected and must receive proper instruction in the task they undertake. Kind hearts and good intentions do not compensate for the lack of natural parents in the case of such children. Their

abnormal traits must be under the care of people who have a very solid knowledge of psychology and social work.

THERAPY OF SPECIFIC ABNORMAL TRAITS IN ORPHANHOOD

Up to now we have considered mainly the social-therapeutic aspect of these substitutional measures in orphanhood. There is, of course, another aspect of this unfortunate social tragedy in children, that of the individual psychopathology. As above mentioned, the pathologic expressions of orphanhood are varied and no unified pattern can be set down. To deal with this matter at all, we must deviate somewhat and separate the actual abnormal social traits from those that we should call the attributive pathologic traits.

Abnormal Social Traits

These are brought to the fore when the orphan develops unnatural feelings and attitudes toward his foster parents. Such hate feelings and acute distrust are not only engendered against the foster parents, but are also transferred to other individuals, even to the entire social environment. This is, sad to relate, quite frequent, and the general maladjustment of such children—especially the nonadjusted foster-parent relationship—is mostly responsible for these antisocial emotions. In half orphanhood overcompensation for the lost parent on the part of the remaining parent or stepparent may also induce negative feelings. In fictional orphanhood a similar situation can frequently be found.

In order to adjust properly this imbalance of feelings, sympathy and a kind, sensitive attitude must prevail. In our case of the indigent child adopted by rich parents, this hate of the foster parents was a major feature of the child's entire behavior pattern. In cases of this sort, the psychotherapist or social worker must proceed very carefully to restore slowly the general positive trust in humanity and the social environment. An older companion who is able to arouse the child's confidence in people will be a good remedy in cases of this sort, and will gradually guide the child back to positive social ties. In some cases it may be wise to allow the relations with the parents to drift until the emotional balance is restored. In our case precisely this measure proved to be

good policy, as eventually, after three months, the child for the first time after a long interval wrote again to her foster parents. However, it took much longer until the wish to see the foster parents arose again.

Therapy of Attributive Abnormalities

This category embraces the various major and minor abnormal traits or symptoms that have been observed in orphans, from bed wetting, nail biting, and lying, to specific phobias. I should like to present a case from my own experience.

Case—

G. was brought to our adjustment clinic by the school authorities because, although a good student, with an unusually high I. Q., he suddenly developed into a disagreeable boy, showing irritability and retardation in schoolwork, especially in arithmetic. In the report, it was specially mentioned that he refused to do subtraction.

G. was eight years of age with definite personality already developing. He was of a specific type, with excellent behavior and showing even a delightful sensitiveness. Half a year before he was brought to us the boy had lost his father, not through death, but because he was sentenced to a long prison term. Left behind were a pregnant wife and three children. Previously of relatively good social standing, the family quickly became impoverished, and the mother from a feeling of shame and mortification refused at first to apply for aid from the agencies that could be approached. The hardest blow came when they lost their large dwelling. Our patient was the oldest of the children and already able to understand what was going on. His breakdown in school was the natural sequence to what he was forced to experience. He felt bitterly the changes of the impoverishment and all that was lost when the father disappeared. He felt the loss of his father the more strongly because the latter had given him most attention, as the oldest child, by taking him on hikes, fishing trips, and the like. Thus these losses broke down his relationship to the environment and considerably confused his ego, to the point of imbalance.

Despite all this the boy retained a close relationship to his mother, and kept a friendly and positive relationship to his social environment. However, though his actual social relationship remained mainly intact, he developed a considerable number of attributive symptoms. He transferred his orphanhood expressions to this attributive sphere. He had lost so much that he refused to give up more. This was the psychologic reason, for instance, for his refusal to do subtraction. He had developed such a phobia of possession that he changed color and became enraged when a sheet of paper given to him for drawing was taken from him. His interest had become so much focused upon the most urgent necessities of life that nothing else seemed to interest him, this causing his disinterest in school and his backwardness.

Our therapy in the beginning consisted mainly in filling in the gaps of these immediate needs. We gradually made him see that it was to the interest of himself and the family that he acquire a good education, so that he might be able to take care of himself and his mother and the younger siblings. His uncle was installed as a father substitute, after the therapist had initiated a transference by acting himself as a father substitute. After about half a dozen clinic visits the school difficulties were a thing of the past, and after a few more sessions the substitution of the uncle completed the cure.

It does not follow that in all cases of attributive pathology the solution by substitution alone will suffice as therapy. Each case and its varied factors must be studied for themselves alone, but always against the background of the orphanhood situation. When such abnormalities arise we must first investigate whether they are caused by individual pathology; if not, we must unveil the other "something wrong" in the life of the orphan. Mostly it will prove that there is something wrong in the substitution and that this needs correction. There are no hard and fast rules to follow. Careful individual study is the task of the therapist, who must clearly know what measures to apply. Under no circumstances can we allow ourselves to be dogmatic in our viewpoints. There are no ready-made cures; we have to feel our way almost intuitively until we find the right solution for each specific case.

SUBSTITUTIONAL AND NONSUBSTITUTIONAL
THERAPY IN ORPHANHOOD

In finding individual solutions we must also take into consideration whether substitution is at all the correct form of assistance to an orphan. It might even be that in some cases it would be wiser to dispense with substitution altogether.

This is eventually the case with orphans of postadolescent age who have already formed specific relationships with people whom they have met in vocational relations or with individuals whom they have known for a long while, and whom they would prefer to be with as against foster parents. Further, in the case of children whose parents have played only a minor rôle in their lives and who have accustomed themselves to other interests in a wider social sphere, parent substitution, instead of being a positive influence, can turn out to become a negative one. Children with lively imaginations and of an introvert type, with little social impulse, may prefer to live with the memory—say, a photo—of the dead parent rather than being coerced into a relationship with “strange” foster parents. Girls in prepuberty frequently develop such attitudes to their dead fathers, and the foster father must be chosen very carefully and his relationship built up very gradually. In the case of fictional orphans, allowing such an imaginary tie to remain has sometimes a much better social and educational influence than a forced substitute relationship.

In fictional orphanhood, on the other hand, it is sometimes necessary even to take steps temporarily to detach the child from its parents. This is advisable in those cases where there was a strong attachment to an unworthy parent, or where the needs and demands of the child cannot be met by the parents because of absence. This latter is especially true at the present time, when so many fathers are keenly missed and the method of substitute parentage cannot very well be applied, because the mother is constantly preoccupied with the absence of the father and the familial discussion keeps the child's memory permanently awake.

Several such cases have come to my attention during recent years. Even three-year-old children develop severe psychosomatic symptoms after Daddy has left for the army. They refuse to eat, develop digestive troubles, and demand that the father's picture be kept permanently nearby, even when they are being put to sleep. Substitution does not help very much here, and rarely by itself leads to success in this type of case. Substitution can be achieved by carefully detaching the child emotionally from his father, at first by gifts and similar suggestive means, until the actual demand for the father's presence has been calmed down to some extent and the child has lost his intense desire for the father's immediate presence and given up the hope for his imminent return. In cases of this sort and those in which there is intense grief over the real death of a parent, it is essential that the grief be alleviated and the child be guided into another attachment, preferably to another member of the family, before any other assistance is attempted. By no means should the memory of the parent be destroyed, but one can take from the child its unfortunate and unhappy influence by bringing it into a positive association with reality.

Orphanhood assistance—I hope I have impressed this point—is not a simple task, but one that requires a great deal of tact as well as application of psychotherapeutic and social-guidance knowledge, and especially, too, of practical understanding.

XII

INCORRECT DIAGNOSIS OF FEEBLEMINDEDNESS*

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AMONG the many cases in which wrong interpretation or superficial study of the basic conditions in mentally inadequate children has led to a diagnosis of feeble-mindedness, two types predominate from a social viewpoint: retardation due to social and that due to educational disadvantages. Four specific cases are presented in this paper, three of which were treated at the Children's Adjustment Clinic of Beth David Hospital, New York City. In all four cases, names and secondary features have been changed in order to make identification impossible.

PSEUDO-FEEBLEMINDEDNESS DUE TO SOCIAL DISADVANTAGES

Case 1—

is that of a seven-year-old colored boy who was sent to the Beth David Child Guidance Clinic by a welfare agency to determine to what degree he was feeble-minded and to suggest measures of adjustment. The boy was born and reared in Puerto Rico, and after the death of his parents the Insular welfare agency to whose care he was referred discovered that his only relative was a grandmother living in New York, so he was sent to the United States.

*This chapter appeared originally under the title "Social and Educational Impairment Wrongly Diagnosed As Feeble-mindedness" in *The Nervous Child*. The paper was cosigned by Debra Safin, my able co-worker in Beth David Hospital Child Guidance Clinic, who prepared the case stories presented in the paper.

The grandmother, almost a pauper, lived in a sort of rooming house in Harlem. A vague charge, either of neglect or of pre-delinquent behavior, led the welfare agency to secure adequate care for the boy.

Routine mental tests, rather superficially given, had shown a subnormal mentality which was interpreted as feeble-mindedness. Our more thorough examination gave a somewhat different result. When seen by us he was in a deplorable physical condition: undernourished, with a heart murmur and infected tonsils.

His personality was characteristic of an underprivileged child. On the one hand, he was shy and suspicious; on the other, he was quick to realize any material advantage, able to adjust himself to existing conditions and to avoid conflict. The rather superior capacity for self-defense was the first definite sign that he was not actually feeble-minded.

Further social study revealed that he had never attended school or received any systematic social training. He had grown up in the Puerto Rican slums, "trained" only in begging and stealing, a sphere of social activity which he attempted to continue when transferred to the New York City slums. However, when tested, not with routine tests but with methods of evaluation adjusted to the possible mental level of a shoeshiner, newsboy, or errand boy, he showed an absolutely normal quotient. During his short stay in the United States he had learned to compute accurately the American system of dollars and cents and was able to read the titles of newspapers and quite a few words, including his own name. He could spell and write phonetically but not orthographically. And he had certainly made a genuine attempt to comply with the demands of his new existence. He was a sort of Kaspar Hauser (46) in the midst of an American metropolis.

The application of some "minimal testing" to determine his educability left no doubt that this was a case of pseudo-feeble-mindedness which, with the help of remedial education and rehabilitation, could quite easily be raised above the level of feeble-mindedness into a low grade of mental ability, impaired of course by his early experience.

PSEUDO-FEEBLEMINDEDNESS DUE TO EDUCATIONAL DISADVANTAGES

The next three cases are identical to the extent that educational impairment has been misinterpreted as pseudo-feeble-mindedness but each case involves a specific secondary factor of different character. These three cases of educational impairment, each with a different secondary factor, give a fairly complete picture of this kind of pseudo-feeble-mindedness and an opportunity to determine specific causes.

Case 2—

The first of these cases was an eight-year-old girl who, at the age of four, lost her voice completely as a result of laryngitis. This was doubtless a severe traumatic experience for the child, who proved to have a strongly introvert personality. The mother, whose statements seemed to be reliable, reported that up to that date the child's development and mental alertness were normal, but that after this experience a strong resistance to any educational influence and especially to any intellectual training developed and increased. The parents made the inexcusable mistake of not insisting on the remedial and compensatory education which is now fairly well established for this form of mutism. Instead, they yielded to the child's refusal to go to school or even to learn to read and write. When, at the age of seven, an administrative educational check-up was made, she was found to be so retarded that only training in an ungraded class would have been possible. However, no symptoms, then or later, could have justified the diagnosis of a definite, specific variety of psychopathology.

Shortly after this check-up the girl accidentally came to the attention of a psychologically trained speech therapist who volunteered to treat the child. After eight months of treatment, her language ability was greatly improved and additional psychological treatment relieved the traumatic conflict to a great extent. When the girl was seen by us, about fourteen months after the beginning of this treatment, she had already attained the second grade in school with the help of private tutoring and there was

no doubt that in another year she would be restored to an almost normal level.

In this case it was obvious that the organic episode was the secondary factor in the pseudo-feeble-mindedness due to educational impairment.

Case 3—

The next case was that of an eleven-year-old boy, son of a couple of intellectuals of the most unsettled way of life. Divorced, remarried, and separated again, their life was a perpetual wandering, partly due to professional requirements. The boy's birth had been a difficult one, but apparently without organic consequences. He had hardly ever lived more than six months in one place. Since he had been able to realize his social situation he had been emotionally part of the conflict between his parents, a situation which, after he reached school age, he had misused in an almost predelinquent manner. He had inherited quite a few of the somewhat undesirable characteristics of both parents. Laziness and boastfulness were mingled with carelessness and egocentricity. However, he had also inherited some feeling for form and ease in dealing with other people. He had never been to any real school, not only because of his wandering life but because his father was convinced that he could teach him everything he needed to know. But all he had been able to learn from his father was the easy adaptability of an irresponsible drunkard who knew all kinds of shady ways to make a living. The mother appeared to be partly artist and partly art dealer and attempted to play a similar underworld game with other men, as her husband did with other women. When the father, with whom the boy had been living for a number of years in California, died, and social agencies located the mother with a view to making her assume her legal responsibilities, she came to us with obvious desire to have the boy placed somewhere where he would be out of her way. Since the agency had informed her that he was feeble-minded, she hoped that placement through a private organization like ours might help her to avoid the financial burden which state aid would entail.

We discovered that the boy had failed all the conventional intelligence tests routinely applied. This was probably because of his love of the roving independent life and because he had been influenced by his father's idea that all society was his enemy to be reacted against negatively. When tested by our methods he proved to be at an ungraded level with regard to the three R's. But he had a rather gypsy cleverness in the conduct of his affairs and, because of his rugged life with his father, his physical health was excellent. He had seen and suffered from the deterioration which ended in his father's death. He regarded his mother as the bad woman his father had described to him. There was no hope of raising the mother to a level where she would be acceptable to the boy even if she had been willing to accept the responsibility of being a good mother. Naturally, we did not accede to her wish to place the boy in an institution. We first tried to find positive roots in his character and abilities. During a course of interviews we tried to give him a different outlook on society and on the possibility of overcoming his father's unfortunate influence by receiving useful training. The approach was successful and we found for him a father substitute who undertook to rebuild his personality. After living for six months in a decent environment, he agreed to join a small school group in the rural district in which his substitute father lived. His rapid mental progress was amazing and it seemed probable that two years of regular school attendance, together with home help, would bring him to a normal level.

In this case the secondary factor, in addition to educational deficiency, was the disorganized family life in which the boy had grown up.

Case 4—

Our final case is that of a thirteen-year-old boy, born in Eastern Europe. After losing his father during the persecution of the Jewish people, flight from one country to another, and several years in a D.P. camp, he came to this country with his physically ailing and mentally exhausted mother, immigrants without means and without the possibility of immediate and positive adjustment. Suffering from a severe form of emigrant neurosis

(*pavor nocturnus*, hallucinations, daydreaming about life in the D.P. camp, fear of being touched, periods of excitement and stammering) and having been without school education for more than five years, the boy should have received careful psychiatric treatment and been placed in one of the classes for "foreign-born" which have been quite successful in some cases. Instead, he was put in a class of boys of his own age in a public school. Of course, he was unable not only to keep up but even to become adjusted. The effort to learn the new language, to master school subjects in an unfamiliar tongue, the educational retardation due to the years in which he had received no regular school training, the strangeness of the new social environment and especially the attitude of his fellow students in ridiculing his mistakes and disabilities, all blocked his adjustment to an extreme degree. All these factors together led to a renewed despair, insecurity, and even actual mental illness. It was not surprising that after a few months the school staff reported that it was impossible to "carry" him any longer in the class to which he had been assigned. They considered him practically feeble-minded. (186).

Obviously the first thing for us to do was to take immediate measures for his adjustment. We promised that he would be placed in a school where individual training and efforts at educational adjustment would be made. This at once prevented him from sinking deeper into his emotionally upset state. It opened a way for psychotherapy, which was immediately started. Even after a few treatments he gave evidence of a quite superior intelligence, although at the time this paper was prepared a definite evaluation would have been unjustifiable. We estimated roughly that at least six months of treatment and careful reeducation would be necessary before he was sufficiently adjusted to enter the school grade to which his age entitled him. He was certainly not feeble-minded and his adjustment depended only on adequate educational methods. In addition to the general educational disabilities from which he had suffered, the secondary factor in this case was the faulty school placement.

These cases illustrate clearly the individual as well as the general aspects of our subject. There is considerable danger of in-

terpreting as feeble-mindedness a temporary inability to function normally in the intellectual and even the emotional sphere if we depend on certain standardized test methods. This has done a good deal of harm in the many cases in which this disability is not a constitutional but a temporary condition caused by environmental and developmental factors which, when recognized and removed, permit the individual to grow out of the so-called feeble-mindedness into a greatly improved and sometimes even normal condition.

The problem with which we are concerned is how to avoid these misinterpretations. We believe that no case of so-called feeble-mindedness should be left untested, in view of the fact that it may be pseudo-feeble-mindedness. The only exceptions are those in which the cause is organic. In all other cases we should carefully check the history and social environment to determine the existence of circumstances such as were found in our illustrative cases. There is no excuse for not investigating the social psychiatric aspect, even though all the formal intelligence and character tests may have indicated a low status. We hope that in the future we shall become somewhat less dependent on these testing methods and shall rely more and more on a totalistic aspect on the one hand and, on the other, the individualistic study of any child whose fate is given into our hands, not for superficial labeling but for the improvement of his tragic destiny.

XIII

BASIC ASPECTS OF THE EDUCATION OF THE MENTALLY IMPAIRED CHILD*

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1. THE SOCIAL IMPLICATIONS OF THE MENTALLY IMPAIRED CHILD

EVEN THE MOST radical educational philosophy, demanding that every individual shall receive the highest degree of education according to his abilities, cannot alone satisfactorily solve the problems that mentally impaired children force upon society simply by their existence. A mentally deficient or defective child is not only a problem in himself and for society in general; he is of the greatest concern to the family into which he is born. Such families are severely impaired groups. The mother who has borne such a child is "mortally ashamed" of him, she is ashamed of going with him into the street, she is afraid of additional offspring; the father has corresponding feelings; and blames occur and disunite the couple. Siblings suffer, and the financial burden caused by him intensifies the emotional stress of having such a "half-human" around.

Helping a mentally handicapped child at the very first goes far in solving his "family trouble." Parents have to be educated to a positive stand toward such a child, and siblings, as well as the wider socio-environment problems, have to be so handled that neither the child nor the environment suffers. Everything that can be done in a purely educational way will depend on the

*I am reprinting here under this title a combination of three addresses given between 1945 and 1947 before educationally interested groups in New York City. These addresses were earlier printed individually in *School and Society*.

arrangement of the seedbed in which the unfortunate youngster is to grow. One may say: "Why take so much trouble? Adjust the child who has so little social value so that he will not be a nuisance and be glad that this is done." Yes, we are glad if this is done. But to do this is much more difficult than dealing with a normal child. The adjustment needed is not so much that of the child as of the environment. Over 60 per cent of all mentally handicapped children are quiet, untroublesome, rather kind beings, but their acceptance by a family or a group is difficult. Bringing about that acceptance is a much more severe task than training them in the limited fields in which training can be given to them.

So tolerantly have we looked upon our facilities for subnormal children that they are the most inadequate help we have produced in any social respect. There is custodial care for psychotic and untrainable children in state institutions. A great many of the trainable and only partly defective and deficient children can really envy those for whom custodial care has been prescribed, since those trainable are completely unsatisfactorily taken care of, mostly left in the care of families which do not know what to do with them. If we overlook the few thousands of subnormal children for whom parents are able to pay \$250 or more per month for their care in the small number of private institutions we have, the 900,000 others—the number recently given as an estimate by the U. S. Office of Education—have hardly anything that can be called a real adjustment training. Since they cannot, of course, be kept in normal school classes, they go into the so-called "ungraded" or "dull" classes, which almost everywhere in the United States have been created more as a charitable than as an educational help. We have here and there special classes for cardiacs and other physically handicapped persons, and here and there special reading-help classes. But only the ungraded classes are available for mentally impaired children. Here they are "kept" until an age point widely differing in various sections of the country. An attempt is made to teach them to read and write, as a general rule, but that is all; and, when these youngsters are released to their families, nothing is done to give them a key to the social living which must exist also for them.

The most frequent argument heard against more intimate and specific training for these children—and it is indeed the most important one—is that each presents educationally such an individual problem that he would need his own teacher. That is true if one takes such a class of “ungradeds” as are thrown together in any public school. This hopeless overindividualistic problem becomes, if not solved, at least directed toward solution, however, if the psychopathologists would step in and sort this mixed group according to the different patterns actually existing: there are mongoloids, spastics, those with behavior disorders, pseudoepileptics, and schizophrenes, each group with a specific behavior pattern and a specific identical pattern from the viewpoint of educability. If, as in the case of physical disease, we put cardiac or deaf or blind children in special training groups, we should pool the different groups of mentally handicapped children according to their kinds of handicap, and we should then have a plan and a basis for educating these children. Each group would prove to need a specific course of education and a specific kind of adjustment.

Here is where our new plans start. We must abolish the ungraded classes and pool impaired children into larger groups, so that entire schools (of about 400) can be run for them. Instead of having the usual grades, we must collect the various types of handicapped children into groups, sufficiently large for each group, from an administrative angle, to receive the right education and the right adjustment. With large groups, it becomes practicable to provide the needed psychiatric and physical care. This is the plan for which we have been fighting through the Child Care Foundation. And we hope to realize in the future a “sample school” of this kind in New York City, which, if it proves to be the solution of the problem, can be duplicated elsewhere.

There is still a third major aspect to the social-adjustment problems of the mentally retarded child, however; and this aspect is the most realistic one. Training such as we usually give to a normal child, even if it is intellectually properly absorbed, cannot mean the same to the handicapped as it does to an individual who stands sound and independent in the competitive fight for our modern existence. Such children would lose often

against individuals much younger than they are. They need to be specially trained from the level of existence determined by their innate constitutions. They are like domestic animals which, to exist in a human setting, must be handed food prepared for them. This final adjustment must be met by a secondary social arrangement without which subnormal children must become tragic charges upon their families. Permanent readjustment is an educational demand that must be carried on through their lives as a continuation of the earlier classes. With schools as we plan them will be connected a permanent guidance bureau to take care of each of these students all the way through life. Some individuals may not need any of this follow-up assistance; others may be permanently in the waiting room of such a service bureau. For this, of course, no prophecy can be made; one can only provide for any recurring need.

2. THE SOCIOLOGY OF EDUCATION OF THE MENTALLY IMPAIRED CHILD

The fact that the mentally retarded child is so tragically neglected in the educational care of our youth is not due primarily to our lack of a sense of social responsibility, but to some basic mistakes in our general educational philosophy. In estimating and evaluating intelligence and capability we apply testing measurements designed to indicate what a child can *maximally* achieve. Our famous I. Q. tests, for instance, and most of our other educational means of judging are of this same type. If a child falls below the denominator fixed by a vague average border line, no specific picture can be drawn of what actually and in detail he is able to achieve. This is a result of the pattern of "achievement races" of which our entire educational thinking and planning is composed. We all know that even a very normal child may have certain intellectual and almost all emotional and affective disbalances, about which we can, unfortunately, do nothing, because our general concepts do not make provision for them in our pedagogical philosophies. No wonder, then, that we have no pedagogical solution for the child who falls below the so-called "average" level and that such a child is committed to the "ungraded classes" in our public schools.

Without doubt, most of us have the sentimental notion that it is the right of each child to receive the maximum help necessary to enable him to lead as happy and productive a life as possible in the society of which he is a member. So say our sentimental verbalizations. But the truth is that our public-school systems have as yet no facilities to care for the 1,000,000 subnormal children who are deprived not only of so-called formal education but also of any hope of adjustment to the life which they could lead if properly trained. In order to establish an educational denominator for these children we could not apply our maximal measurements; we would have to use *minimal* measurements which would tell us precisely how much a child, even one at the lowest level of capability, can comprehend and learn. Such minimal measurements, however, would require a complete change and revision of our basic educational philosophy to embrace each and every member of our society and to become the first real democratic philosophy of education in the sense of the "democratic ego," which we have up to now so sadly neglected in our educational thinking (144, 162).

Families faced with the problem of education for the mentally retarded child know that there are not more than one hundred small private institutions available and that their fees are acceptable only to those in the upper financial class. These institutions give some kind of shelter and occupational instruction, but often offer far from satisfactory education and to only a very small number. The majority of mentally deficient children, if admitted at all to public schools, are given an "ungraded education" only in the things "they can do" and, as the ultimate in "opportunity," permission to stay for two additional years in some occupational training class, while attempts are made to give these children "academic abilities" that normal children acquire in the first or second grade. This is the result of thinking in maximal educational terms. If we were to change to minimal concepts we would ask what must be done to enable, if it is at all possible, every child of subnormal capabilities to earn his own living and to make the best social adjustment possible. This would demand a much higher degree of effort and also much greater financial support than are usually granted for the

normal or even for the superior child. Maximal educational thinking again and again has argued against this demand; that it is socially not worth while to spend so much effort on the child who does not represent any concrete value in our society. If, however, one were to take the wider view and consider the social and familial disturbances created by the subnormal child and the effort which has to be expended on him eventually, one would see that well-directed educational effort often proves to be the smaller expense (151). At this point one can readily realize that more realistic and better adjusted thinking with regard to the subnormal child must give up narrow, schoolmaster methods and advance instead to sound sociological study and planning.

If basic concepts in sound educational planning are to be developed, the problem of care for the subnormal child must be approached from the *sociological* angle. This forces us to step beyond the limits of considering only strictly educational problems and to include also those of medical, psychiatric, psychological, and social adjustment (102). In dealing with mentally deficient children we must bear in mind that the lowest category of subnormal children includes a variety of types. There are those who are completely unfit for any kind of educational adjustment to the rest of society and for whom the only possible social adjustment is custodial care in an institution for the incurably insane. The next higher grade of subnormal children includes those who need long medical and psychiatric care in an institution with some small hope of becoming able to live outside the institutional setting.

Many may question why this lowest type of subnormal children is included for educational consideration. The principal reason is that we can envisage both therapeutic and educational care together, and thereby train ourselves to acquire a *total view* of the needs of any type of child. Even in the highest groups of deficient children some kind of therapeutic care is necessary; today this care is almost completely neglected in our larger school systems. As soon as a child is classified outside the present training pattern, he is dumped into the ungraded classes, and generally the therapeutic aid granted the neurotic child through

child-guidance clinics is not given him. If we wish to do not only what is best, but also what is elementarily necessary, we must give any child at any time all the therapeutic assistance he may need. And this all-inclusive therapeutic treatment must be enforced even with the highest types of retarded children. We can never know but that our diagnosis and treatment of even a seemingly obvious organic defect or mental arrestment may prove incorrect and that correct diagnosis and treatment would advance the child considerably. I have found that a number of even our high-priced private institutions completely neglect active therapeutic treatment and regular check-ups. Even where we are convinced that we are dealing with only an intellectually retarded child, there is still the therapeutic question to be considered.

But let us return to our classifying description. Even the child who will be permanently institutionalized should receive some educational assistance with the aim of making his existence easier. Most of this educational help, naturally, will be in habit training in primitive life functions and homemaking abilities, together with some training in so-called leisure-time activities, and, if possible, some primary intellectual training. Even if the hope that an institutionalized child may be returned to a family environment is small, we should keep in mind this possibility in our educational approach to him.

Where there is the possibility that a child may be developed to the point where he can take a place in society, either in a family setting or even on his own with complete responsibility for himself, we must take the step toward a totally conceived educational program, which has as its final aim the training of the individual child for the highest degree of adjustment to life that he can attain. We should discard from the beginning the intellectual theories almost solely applied throughout this country. We must remember first to teach the practical things that a human being should learn and know for simple living in our modern society, and our final aims must be the highest possibilities we can achieve for these children on an intellectual or creative level. Unfortunately, we are hardly prepared in any respect

properly to assist educable mentally retarded children. The greatest lack is that we have not yet developed individualized educational systems for the various types of children (171). There is no doubt that we must have different educational setups to train and adjust mongoloids, schizophrenics, and spastic children, and behavior-disorder types, to mention only some major groups. Those working with a mixed group of mentally impaired children know that one case of behavior disorder often makes any active work with the others almost impossible because of the one child needs constant watching and holding back. Our remedial workers knew very well already that a child with a schizophrenic pattern of thinking needs a completely different kind of adjustment than does, for instance, a child with an involutionary hysteria pattern. Children with partial disabilities, such as blindness to certain types of words or numbers, or linguistically impaired children, need specific courses of treatment for proper adjustment.

The moment we are willing to tackle the problem of total adjustment for these children, we must also give up the halfway adjustment measures so characteristic of certain private institutions, which make it their sole aim to train their small group of subnormal children to behave without negative attitudes in their wealthy parents' homes, to read and write, to do simple arithmetic, and to take part in some expensive sports. This, of course, is exactly what such parents want in return for their often lavishly spent money. The moment such a youngster, by some social accident, is deprived of this well-to-do environment, however, he becomes entirely helpless and unable to live outside an institution. Total adjustment must, therefore, attempt first to give these children on a sound basis the ability to live happily in the community, and, when this is achieved, a more refined and higher education can be added. We know that some subnormal children require a very slow teaching process to learn what a normal child of kindergarten age grasps in an hour. There are those who seemingly possess a fairly acceptable intellectual ability, but who actually are unable to activate or to memorize at all.

Further, under no circumstances should marked distinction be

made in evaluating the intellectual and the manual or social abilities. These should all be placed on the same level of evaluation. Educating a mentally deficient child means an enlargement of our radius of pedagogical knowledge concerning the sphere of the intellect, and the addition of some new emotional and action concepts to almost the whole of social experience. Even most of our educators with a leaning toward remedial education show interest only in a specific field and are, accordingly, willing and able to offer only some specific training to the general instruction aspect for the normal child.

If we honestly wish to try to solve in a *total* and *sociologically sound* way the problem of the mentally deficient child, we must develop a total educational system *based on the minimal measurement of abilities and on the pluralistic aspect of the various types of disabilities and so realize the whole educational possibility for each child*. It is the trend of all remedial education today to solve the problems in a differential way, by having, for instance, one class for cardiacs and another for hard-of-hearing children, besides the tragic "ungraded" classes for the mentally deficient child. The solution lies in creating schools for the various types of mental deficiencies all of which could encompass in one framework a school in which work with every type of disability is incorporated, in a single network so organized that it can fill the individual needs of each and every different category of mentally retarded child. This cannot be achieved with a small group of children. A large enough group is needed to make it possible to procure all the necessary equipment and staff at a reasonable expense.

3. THE TRAINING OF TEACHERS OF MENTALLY HANDICAPPED CHILDREN

The following paragraphs pertain to the present state of education for the training of teachers of mentally handicapped children. Hardly any other corner of the wide and varied field of education is more neglected and superficially regarded than this one, which should and must be given a central rôle of impor-

tance from the standpoint of the rehabilitation of the subnormal child. Almost a hundred years ago, humanitarian interests opened people's hearts to the physically handicapped child—especially to the child afflicted with blindness—while the mentally handicapped child at the beginning of the century was still looked upon as an unworthy creature, beyond help, not even to be considered human, and certainly not within the range of the responsibility of society. However, whether they were mass appeals, such as the polio drive, which have made society aware of its responsibility toward any child belonging to it, or a certain growth in humanitarian feeling for the total responsibility of society toward each and every member, as we offer it to the aged and the injured, or the increasing, almost neurotic, interest in nervousness and mental illness, nobody can deny that during the past two decades we have begun to be conscious of a certain duty toward the mentally handicapped child.

At first this interest amounted to little more than an attempt to fight what might have been a nasty virus condition which had to be eliminated by extermination means. From this approach grew research and statistics which, even though much of it was not too reliable, proved beyond dispute that there are always in every generation more than a million children under twenty years of age in this country who cannot be taken care of educationally by our public schools and who should receive therapeutic or remedial education. In this period there were established also, but only for upper-class families in America, some hundred private schools for subnormal children; they offered help only to some six or seven thousand of the almost one million children of this type. For the other hundreds of thousands we now have so-called deaf and dumb institutions or the inadequate ungraded classes. These are open only to children whose physical and mental condition enables them to be schooled outside mental institutions. (The horror of our mental institutions and their appalling lack of facilities for children is a chapter outside our present topic.)

Next came the second period in our sense of responsibility toward the mentally subnormal child. Probably created by progres-

sive educators and psychotherapists who attempted to break through our entire pattern of competitive education and establish a system whereby individual possibilities and impossibilities were considered, this second period had severe moral social pressure behind it. What the precise cause of this pressure was cannot easily be determined, but it demanded that more be done for the mentally handicapped child. The result was that every teacher's college and every educational training school in the country seemed to feel some kind of moral obligation to present courses in remedial education. Few, however, had any idea as to how their knowledge of work with mentally subnormal children should be applied. The truth was that it had only been a superficial sentimental impulse that had created this so-called sense of moral obligation which clearly showed us, not only in its general and in concrete aims, but also in its execution, the regrettable shallowness and corruption of the basic impulses of our entire educational philosophy and administration.

Professors of education who had never worked practically with subnormal children "offered" remedial-education courses sloppily thrown together from books such as those by Bentley (23), Heck (95), Baker (11), Fernald (45), and clinical psychologists. Some schools even announced practical courses, which consisted of a superficial collaboration with nearby asylums or state institutions where the children were "observed" in much the same way that rats are observed in animal laboratories. Some sharp-witted, irresponsible, opportunity-seeking young scholars, who foresaw the possibility of a new public career and a chance to get the publicity they wanted, even organized entire departments for training teachers of handicapped children without having had the slightest training for any kind of acceptable instruction themselves and without the barest essential facilities for such instruction.

We are facing in such irresponsible training centers one of the most insidious educational rackets of today. Nothing is more important than to eradicate this evil by creating proper educational training facilities for teachers of the mentally handicapped child so that the impulse to help him, which in itself is sound, will not

be directed into wrong channels or crystallized into a superficial unbreakable pattern from which it will probably be more difficult to free it than to ameliorate the entire situation that has created this impulse.

When I attempted to present concrete proposals for adequate training facilities for teachers of mentally handicapped children, I believed that I had the right to do so by virtue of the fact that I have been working for over a decade on plans for such training. I wish to emphasize this because I am aware of the responsibility involved in such proposals; a good portion of my task is the spreading of the awareness of this responsibility.

Today the teaching of subnormal children is still generally considered a somewhat mediocre educational pursuit. Teachers who, for this or that reason, have been disqualified or disabled for the regular normal educational positions find themselves teaching in private or public ungraded classes for handicapped children. Only under the influence of clinical psychology has the realization come that working with such children must be considered pedagogically a higher and more difficult work than that of conducting the "normal" classroom activities with normal children. This means also that such teachers must have a more intensified, long, and specialized training. Earlier in this chapter I developed an educational philosophy and explained why it is worth while for society to devote intensified effort to the mentally subnormal child. This effort must, of course, be directed in the first place to our teaching facilities and to our teaching personnel. A teacher who wants to serve in this capacity must have not only the basic and primary ability to instruct the normal child, but the *additional capabilities* necessary for working with the subnormal child. We must, therefore, demand that any teacher of subnormal children complete his basic training in the education of normal children and that training for teaching subnormal children include additional graduate work. No education for such teachers can be sound or adequate if it is not composed of at least a B.A. degree in education and an additional M.A. degree in work with subnormal children. We maintain, therefore, that satisfactory education for teachers of

mentally handicapped children should be conducted in specially arranged graduate courses for remedial education or, as we shall propose below as the best form for this education, in special colleges or graduate schools for remedial education.

Looking at our present methods of training for teachers of subnormal children, we see almost nothing offered in the way of general theories or detailed practical suggestions in the few individual courses given as a sideline to majors in education in our colleges. Our knowledge of the personality structure of the mentally handicapped child, however, is actually so far advanced that we know such training to be absolutely inadequate. We are aware, for instance, that it is not enough simply to know how to teach braille reading to work remedially with the blind child. And we are aware especially that most speech abnormalities not only mean the inability to use the language mechanism in a normal way, but are symptoms of a variety of psychopathological conditions (as we know that headaches can result from a dozen or more different causes). A speech therapist, therefore, has to know a great deal about the wider and more complicated fields of psychopathology and psychotherapy. Blindness and speech pathology are, after all, among the less serious psychological disadvantages. When we come to the more serious types of mental abnormalities and their respective readjustment requirements, such as behavior disorders, schizophrenia, hysteria, or mongolism and cerebral palsy, far greater learning and ability in dealing with personality abnormalities and readjustment are needed than can ever be acquired by present teaching methods in remedial work.

Such a teacher, in order to be prepared properly for this work, needs at least two or even three years of intensive college training, starting with physiology and psychopathology and ending with special social-work courses and actual field work. We cannot be too conscientious in affording a thorough all-around education to the men and women in whose hands are to be entrusted the education and the problems of adjustment to normal living of the subnormal child. Until we are willing to give up our present superficial basic concepts of remedial education,

we will not, of course, see the basic requirements for the kind of colleges that will produce perfectly trained remedial teachers materialize. And we will never have the proper kind of remedial teacher until we develop special colleges for this purpose and a training system planned to stretch over a period of years.

One of the major problems in the realistic approach to proper training for remedial teachers is the question of actual working contact with the children they hope to serve. These students of remedial education must be given an opportunity not only to observe and study the various types of handicapped children at first hand, but also to practice teaching these children under supervision and to witness advanced methods as demonstrated by well-trained workers in the field. The only facility offered along these lines is the occasional observation of subnormal children in whatever institution happens to be within reach of the school. If we wish to see any real and lasting results in respect to this most important part of remedial education, we need to form schools for subnormal children which would be suitable as basic training grounds for teachers. Certainly our ungraded classes are not suitable for this purpose; neither are our state institutions. What remains in the present state of affairs is a small number of private schools as possible training grounds for teachers. Of these there are just a few which accommodate a large enough number of the various types of abnormal children to be at all suitable for training purposes. To mention one of these I may point out the Devereux Schools. Even the best of these private institutions, however, are not ideally equipped to become model schools for teaching remedial methods.

What is needed is proper training equipment for the education and readjustment of all the various types of subnormal children. Earlier we pointed out that it is necessary, for instance, to use an entirely different educational pattern and procedure for the schizophrenic from that for the behavior-disorder patient, and still another approach for the mongoloid group—to say nothing of the elaborate and individual techniques needed in dealing with children suffering from cerebral palsy. There are to my knowledge in the Eastern States only two institutions at present with

facilities that I could consider suitable as training centers for teachers of subnormal children—and then only certain types of subnormal children: one is the Widener Memorial School in Philadelphia and the other is the J. J. Putnam Children's Center in Boston.

XIV

SHORT-TERM CHILD GUIDANCE IN THE CLINICAL FRAME

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DURING 1946 the Medical Board of New York's Beth David Hospital invited me to set up, within the frame of its Dispensary Service, a Children's Adjustment Clinic. No other specifications or requests as to the specific form of this child guidance unit were made, except that it should function as a part of the hospital's pediatric division. This invitation presented a unique opportunity to bring into functioning a real short-term guidance clinic, a plan for which I had been preparing myself by working for a long time on similar projects under less ideal conditions than those offered to me by Beth David Hospital.

In executing the task for the Beth David Child Guidance Clinic, three basic problems had to be taken under consideration. First was that this clinic had to be, as closely as possible, adjusted to the specific problems presented by the conditions of the specific area in which the hospital is located. Second, that no means of financial support, beyond those for general dispensary expenses, were available. Third, that we had to create a clinic which was not for specific limited service, but for a mass service, accommodating as large a number of children as possible. All these three needs pointed in the direction of a short-term form of child guidance clinic.

I consider it important to give a detailed description of the Beth David Child Guidance Clinic, because I believe that we have succeeded in developing a unit which can be considered as a pilot institution for most underprivileged areas, rural as well

as urban. However, I wish to emphasize that I do not believe that any pattern for such an institution should simply be imitated or copied. There are individual conditions in every social environment which must be taken into consideration, and to which an adjustment must be made, if the aim is to give satisfactory help. The Beth David clinic is an example of a very well adjusted working unit. To describe it we must, of course, describe the various conditions upon which the institution has been built.

We shall describe here in more detail the three basic problems which were essential in determining the form in which the clinic developed. Beth David Hospital is located on the east side of the Borough of Manhattan, on the border line between German Yorkville and Spanish Lower Harlem. The area is occupied by poor German, Puerto Rican, Spanish, and Jewish groups. The hospital calls itself "nonsectarian" and accordingly draws its patients from all the neighborhood groups. At the time that plans for our service crystallized, we visited the principals of local schools. One of them told us that one quarter of his school population needed some sort of advisory assistance either for the child or the parent, and that there were no satisfactory facilities available, either through the school system or from any other official or private organization. We were also informed by the administration of the dispensary of Beth David Hospital that there was a great influx of parents with children with undeterminable conditions which seemingly could not be completely satisfactorily handled by the pediatric division, without child-guidance help. On the other hand, the type of case which was reported to us was, evidently, not primarily psychiatric or neurological, but belonged to the general category of social pathological and guidance cases. This made it evident that we needed, not a psychiatric clinic for children, but a child-guidance clinic with social and pediatric services as main features. Leaving the final form to the needs and experiences, as they would develop during the operation of our clinic, we started out with an administrator (clinical psychologist) at the head, a pediatrician, a social worker, and a clinical psychologist as the skeleton staff. The clinic itself was part of the dispensary of Beth David Hos-

pital, and through this a psychiatrist, a neurologist, an endocrinologist, as well as any other medical services, were available at any time that we needed them, or felt that a consultation with any of them was advisable.

Formally, we were under the supervision of the head of the pediatric division of the hospital, and all our workers were required to meet the academic standards set down in the official status. The name and vita of every worker were filed with the administration, as we were requested to report in detail about our activity. Another factor which determined our selection of staff was our financial status, a dispensary service without salaries, at least during the first two years. To have the best qualified workers we had to limit service to short shifts of four hours, with the exception of the administrator and clerical help. This made the direction of a case to the same worker not as easy, administratively, as we might have desired, but we succeeded, using the aid of a staff chart, in organizing a smoothly working system. According to the dispensary rules we were permitted to charge a minimum fee; however, since almost 95 per cent of our cases came from the most underprivileged groups, the financial intake of the clinic was very small. Needed equipment was supplied by the hospital, and in some cases our workers generously contributed materials themselves. Our experiment was carried, at all times, by the enthusiasm of the workers, which gave it an unsurpassable standard of responsible work.

As was expected, a great number of clients soon appeared at our new clinic requesting help and we had to work in a way that would make mass service possible. Mass service can only be meaningful if it is able to work quickly and efficiently. All lengthy and unnecessary procedures had to be avoided and whenever possible eliminated. We will show how we were able to shorten and quicken our help by doing as little written reporting as was possible, and by developing a special form of code for our record use. As part of this process, we used the quickest form of communication with other agencies, when we needed exchange of information or referral for service. We eliminated unnecessary waiting and return to the clinic whenever possible. And last but not least, we shortened the process

of examination, diagnosis, and therapy wherever this seemed justified. Shortening does not mean, however, as we shall show, that the conventional short-term therapy procedures always were used. Short-term means adjusting the service to the case so that the quickest results may be achieved. We wish to emphasize that we never desired to eliminate careful examination, or even lengthy testing procedures, where they seemed necessary for a reasonable insight into a case, nor did we consider short-term to mean a shortening of the therapeutic procedure, where careful long-term treatment has been proven to be the only correct, and therefore the 'shortest' therapy (36, 94).

Before the clinic opened specific limitations were set, as a basic part of our plan; as to the kind of cases we would accept for treatment. We felt we should exclude any serious physical or mental disability. Neurological cases and any definitely established mental illness would not be treated by us. However, we made it a point, as one of our rules, that no one would be turned away from the clinic without receiving at least advice as to where to go, and if possible a definite appointment with any institution which we felt would be able to handle the case. We served as a clearinghouse for all social, physical, and mental ailments outside our treatment possibilities, and we kept a good many persons we referred to other agencies in a social-service connection with us, in order to be able to check on the success of our referral and to help in any cases where additional help became necessary.

In describing the actual functioning of Beth David Child Guidance Clinic, we have to start with outside contacts. Shortly after the opening of the clinic was announced, we were overwhelmed with a great number of requests, which very soon went far beyond what we were able to carry. We added workers, but limitations were imposed by the amount of space and time at our disposal. The local public and parochial schools, the local police station, the Juvenile Aid Bureau, and our own dispensary service fed our clinic. To channel applications a simple arrangement was made in the form of a request that persons making referrals should contact us four days before the weekly clinic, in order to have a definite time set for the patient. This

permitted them to have the child on hand at a specific hour and allowed us to be prepared for the individual case. In scheduling our cases an average of a half to three-quarters of an hour was granted for each case, except for admission cases, for which a full hour was assigned.

For all such referral cases we requested a short (no longer than one page) report on the case. We had quite a difficult time in winning certain professional workers to our short, precise form, for many within the public authorities systems were trained to the policy, "the longer the report, the more efficient you seem."

ADMISSION

For each child admitted to our clinic a direct application, in person or in writing, by either the parent, guardian, school, or official social agency, was required. In cases where the child came alone, referred by a playmate on several occasions, a document of agreement by a legal representative of the child was obtained before the child was admitted. As in all our work, quickness, adaptation to the need, and a minimum of bureaucracy were applied in the admission procedure. We omitted long waiting by giving appointments for specific times.

Under normal conditions, admission meant that a child was seen at the same time by the administrator, the pediatrician in charge, and a social worker. During this admission session, we tried to find out as much as possible about the child. A physical examination was given and as much as possible was filled out in our child-guidance form. This form was developed by the writer to suit the purpose of a short-term clinic. Since the special character of our work is of such importance, I feel justified in describing it here.

THE HARMS-BETH DAVID HOSPITAL CHILD GUIDANCE FORM

Any fast-working service is dependent upon efficient, quick, easily accessible information on and survey of an individual case. The failure of many of our public and dispensary services is due to the fact that they follow an old pattern, which has as its principle that the quality of a medical or psychological report is re-

lated to its length and detail in covering a case. To advance a case of which 24 to 30 typewritten pages have to be absorbed, needs an hour or more in preparatory reading.

Our form was developed to make it possible to get insight, almost at a glance, into the major features of an average case. The entire form consists of a double quarto sheet. The front gives all the factual information of the case. On the inner front page short notes on progress of the case are entered by each worker who takes part in it. If additional documents are accumulated and if more notes are necessary, they are made on additional sheets, which are kept inside the double sheet, which acts as a folder. On the front, one will find space for the personal and familial facts. Space for a physical, social, psychological, and psychiatric examination and evaluation follows. All this information is to be presented in the shortest possible form. Not all the facts are to be noted down during the first examination of the case, but are made during the progress of the case. They are the more or less definite and final opinions which may be accumulated during the months of working with the case. The front page, if properly filled in, will give a clear objective survey of the status of the case.

It may be added that the sample given here is one constructed for the purpose of showing an ideally filled in form.

Besides starting the filling in of the file form, the task of the admission interview is to clear the social and physical status of the case, together with the determination of whether and in what section of our work this case should be admitted. As a general principle, no child is to be admitted to the clinic before it has undergone a thorough medicophysical examination, determining, at the same time, whether or not its mental status is beyond our ability of treatment.

However, it has been and always will be our principle in our short-term pattern of child guidance, that regulations which are in most cases justified, are put aside if the individual case and the success of that case demands it. We present two cases:

Case 1—

D. N. is a fourteen-year-old boy, badly maltreated by his home environment and badly placed in a wrong school and class. He

has been truant, and for periods, absent from home, bitter, undernourished, and in a serious depressive mental state. Picked up by the police, he created a scene which made the police officer suspicious of his mental state. He requested his internment in an observation ward of a municipal mental hospital, a period which increased the boy's mental upset. When he was brought to us he was in such a state of suspicion and despair, that any attempt at routine procedures would have upset him even more. We suspended any medical and social investigation and immediately began psychotherapeutic treatment, in order to establish this youngster's confidence in us and in the others who wished to help him. Especially, however, in himself. Medical examination took place after the third time he came to the clinic.

Case 2—

B. S. was a seven-year-old girl, with a strong ego inflation, due to her growing up in a ghettolike social environment which gave her a great deal of insecurity, fears and unfulfilled wish-daydreaming. Her insecurity was raised to the phobia level when a classmate was shot in an accident. She not only refused to leave the house alone, but she did not want to go to school any more and became a serious feeding problem. When medical assistance became involved with injections, she concentrated her fear upon any medical or even white-coated person. Our approach, of course, excluded any medical assistance and concentrated at first on building up sound social contacts and the removal of the traumatic conditioning of the phobia. When we had her back at school and at sound play in the neighborhood playground, we ventured an approach to a physical examination. We had at that point an almost cured child. The medical examination had to come at the end rather than at the beginning of therapy.

Besides starting to find the general status of any case, we write in shortest form the action taken at every individual visit and the progress achieved. One finds the follow-up reporting on the status of a case on the page following the face sheet.

It has always seemed to us to be a sound pattern of child guid-

ance to have the parents drawn into the case, and, if possible, to have an interview with them even before the child is admitted. We have always tried to have at least one interview with the parent; however, we have not made an issue of this if it was not definitely essential. As stated before, more than half of our young clients come directly from the schools and agencies which have themselves acquired the parent's consent to sending the children to us. Where it has proven helpful to have the parents come to the clinic we have made every attempt to do so.

One of the major tasks in the admission procedure is finding out in what category of treatment the child is to be admitted. Soon after the start of our work, we found that we had special types of case among our clients. Again we simply made arrangements to meet this task. I know that in every locale different conditions exist and that there are only a few guidance centers which will have exactly the same needs as those encountered by us in New York's Harlem. We found that we received a high percentage of children with speech impairments, which meant that we had to employ two full-time speech therapists. An equally high number of children proved to need remedial reading help, so that we had helpers, working four hours, permanently occupied. Besides this, we had a large group of adolescent youngsters with specific adolescent problems. We had, for a time, two workers specializing in this type of case.

After the classification of a case was determined, it was given to one of the workers "to try him." By this we meant that we were not dogmatic about having a child with a single worker for a long period of time, or for all the time. Only if a positive contact and collaboration between the child and the worker proved evident did we have them working together permanently. The opinion held by certain groups that the personality and the organism of a guidance institution is unessential for the treatment as such, is not accepted by us. We are interested, in our short-term clinic, in as quick and efficient treatment as is possible. Therefore the best available person, who can be most successful with a case, is what we attempt to find. We give a far higher importance to the personality of the case worker, as regards his

possible effectiveness in treatment with the child, than has been given by any other psychotherapeutic school.

SHORT-TERM ASPECTS OF THERAPY

Although we have as our basic principle the effecting of cures in the shortest possible time, we have never dogmatically planned or predicted treatment. As abnormal psychology stands today, we know hardly anything about the temporal course of mental disease. Cure can only be recognized by its real appearance. We have also never hastened a cure by any pushing which would make it superficial or even preventing its success. We know that in many present therapeutic procedures the financial angle plays a considerable rôle. It must be emphasized that our clients, if they pay at all, pay only a small sum for the treatment until cured, no matter how long this may be. It seems essential to mention here again that we are fully aware that there do exist in the field of mental illness those cases which are purely custodial, where there is no possibility of achieving any cure. Similarly, there are in the field of guidance those cases the proper handling of which means long-term and even permanent guidance care. We presented two types of cases seen at Beth David Child Guidance Clinic, both of which were carried by us for over two years.

Case 3—

L. L. was born to a very young mother, who was abandoned by her mate before the child was born. Her parents, with whom she continued to live and who actually took care of the child while she earned her living, never forgot the daughter's misstep and openly accused her, in front of her growing child, of her shameful position in life. The grandparents, not able to speak English, lived in one of the worst slum areas in the deepest poverty. The only education methods applied by them were the strap and rude language. The neglected child was a predelinquent when finally presented at our clinic. We had to take over the supervision of this child and shall have to continue until it has passed out of our authority.

Case 4—

F. A. is a 12-year-old boy of Near Eastern descent. He was sent to us as a truant and a specialist in hand-to-mouth stealing, which apparently provided the major part of his nourishment. His home environment and social background had not given him any property sense, which we consider basic for our Western civilization. There was no help from his family and his teachers had "given him up." He was the most friendly and willing boy when under direct supervision, hinting again and again that he was not able to promise that he would "be good" when "off the ropes." This boy definitely needed guidance until such time as the social environment or probably marriage would give him a responsible guide. We undertook to supervise this boy "indefinitely."

Passing from the primary admission procedure to the actual investigation and observation of a case, we must discuss our policy regarding formal testing with any kind of standard test. This has become a completely brainless, routine procedure for almost all child-guidance institutions in this country. The author has for nearly three decades opposed the rigid procedure of standard testing of intelligence of the major part of the inner life of the individual. Tests should be tools in the hands of adjusted observers, not of unguided apprentices, and not impersonally showered over any person that comes within the range of these ghost methods. If one is realistic one would say that psychologists in this country have made a lucrative business of making and selling tests, and they certainly understand how to sell their product. In view of our interest in short-term therapy, it seems almost a crime to apply lengthy test procedures which will not even give results which have research value.

The application of testing in a short-term setting has two main features. First, tests should be applied only when they are really necessary, that is, where quicker and simpler methods of investigation have failed or where tests are really found to be informative.

The contribution by the workers at our clinic, in the chapter on feeble-mindedness, is a clear example of the use of intelligence evaluation in a very selected manner. This has become the prac-

tice for us in all our investigations. We apply tests only where we are sure they are needed and when we can secure usable results. This is valid for all general tests. Of course, there are those cases where specific capacities or disabilities are involved, such as reading deficiency, where we have made exhaustive use of means available for determining the scope of the deficiency. But we have been very selective, using only the most efficient methods. Several tests were used, side by side, only when we were sure that one did not give satisfactory results, or where we needed to study various aspects of a complicated case.

The second point regarding testing concerns the application of actual short-term test methods, of which very few are available. This author has for years been experimenting with such brief test methods, but has restrained himself from publishing his methods, not because they are not ready for wider use, but because their use requires familiarity with and acceptance of short-term therapy. Students and coworkers of Beth David Child Guidance Clinic have learned to use these methods and have profited considerably from them. The actual practical learning of these methods seems, at least at present, to be the only sound way to communicate them. We hope that in the not too distant future we may be able to give the proper background for the publication of some basic brief testing methods.

All testing, to be worth while in short-term work, should be definitely aimed at the needs of quick procedures and should be coordinated into the total plan for the treatment of a case.

What I have called here the total plan cannot be emphasized strongly enough. Especially, it must be accepted and understood, not as a dogma of any kind, but rather as the coordination of everything done by us with the idea of quick and efficient help. This is particularly true in the actual treatment. I hope I need not stress that no "wholesale treatment" has ever been applied by us, nor must I emphasize that I do not believe in it. We have hardly ever applied group therapy, except in situations which I like to call family-therapy, with the inclusion of one or both parents in the therapeutic process. However, in some situations we have taken a few of our clients together. This has been particularly successful in remedial reading. We found that working to-

gether gave courage and encouragement to some children. The Kingsbury "Go Fish" quartet game has been very successful when applied with such groups—so much so that some children have wanted to play it alone when the worker was unexpectedly absent. In some cases we have applied exemplifying group techniques where we felt unable to get ahead therapeutically by any other method. In general, we have found that individual treatment still leads to the fastest results in a short-term clinic.

Of course, the first selection of a treatment plan by the intake group has never been dogmatically determined, nor has any plan been retained beyond the time that it has been shown to be wrong or not best for a particular child. We have always tried to find for the individual child a worker who would appeal to him. Since we deal to a considerable extent with a foreign group, we try to use a worker who is able to speak the language of the child.

When the worker is given a case, he becomes totally responsible for it. He makes the appointments. He sees to it that the physical therapy or any other social remedies are carried out. As we mentioned before, in all cases where it was not forbidden by special circumstances, we tried first to improve the physical condition of the child and to have all examinations which the pediatrician considered necessary. However, the case worker had to limit himself to the connections within the clinic and the hospital. Outside contacts, if necessary, were handled in connection with or through the clinic administrator.

Very essential for our short-term viewpoint has been the policy regarding the selection of treatment. In cases where a specific disability has to be treated, the solving of this problem is simple. Children who are sent to us for treatment of reading disabilities or speech deficiencies were, of course, referred first to a special worker. A diagnostic approach was maintained, since it was necessary to determine whether this specific disability was more or less limited, or whether it was a symptom of a more complex illness. From the result of a first observation, it was determined whether psychotherapy or any other therapeutic assistance had to be added, or whether the primary factor was the removal of

the specific disability. This decision was made during the child's first visit to the clinic, wherever possible.

The decision upon a treatment plan was more difficult in those more or less complicated, primarily psychically or socially determined cases. If during the admission session no decision could be reached, a case worker was assigned the case for observation to determine the suitable therapeutic method. As mentioned before, we have always admitted only those cases which definitely did not fall into a psycho- or neuropathic category, since we were not equipped to handle those. Such referrals to other agencies or other treatment centers were also undertaken, when, we, in the course of our handling of the case, became convinced that this would benefit the young patient.

It has been a basic view in this writer's therapeutic thinking that a particular therapeutic concept should be applied only if it is proven to be in accordance with the patient's kind of mental structure. My basic concept is based on the belief that the differences in the concepts of the masters, for instance of Freud, Adler, Janet, and Jung, result from the kind of psyche or type of mental structure they themselves had. There is always a group of individuals who have had a similar or the same conditioning, and those are the people who can be cured with a corresponding concept. Specifically, people with a Freudian mental structure can and should only be cured with Freud's concepts; people with a Jungian mental structure, only with the concepts of Jung. In a clinic where children from all ways of life are brought in, and where there is no specific psychology or psychotherapy officially determined, it has always seemed to me to be the only just and decent attitude that such a "middle of the road" stand be taken. We did this at Beth David, and in the first admission session we tried, wherever possible, to determine which concepts should be used or tried. However, I must emphasize that only in a very few cases that came to us was actual psychoanalysis considered the correct method. Here is an example of such a case:

Case 5—

F. F. is an asthenic Jewish boy of eleven, who had come to the United States only two years before he was sent to us. He had spent most of his earlier years in prison and D. P. camps. The great hope of being in a land of easy living was quickly destroyed by unfortunate experiences. The boy, instead of finding consideration, had a hard time adjusting to American schools. Nevertheless much of the regressed experiences of the earlier horror years came to the psychic surface when the worst dangers proved to be eliminated in this country. *Pavor nocturnus* continued and severe fear spells, fear of the dark and of falling asleep continued. There had to be removed a great deal of traumatic material, for which analytic treatment seemed doubtlessly the only correct and the fastest way.

In most of our usual cases, general handling, at least in the beginning, was the most recommended way. Fortunately we had workers from all the major schools at hand, which increased the possibility of having the correct method observed.

One of the most essential points in our clinic setup was the collaboration of the members of the staff upon the individual cases and the reports of progress. It is our idea of the administration of a short-term institution that the administrator actually should be in a position of supervisory control of all cases handled in the clinic. This can, of course, only be done where the institution handles not more than about fifty cases at a time. If such an institution grows much larger, a division of supervision seems advisable. Such a division may be best arranged if the supervisor is appointed for a specific type of case, as for example speech deficiency and remedial teaching groups.

However such supervision is arranged, it should be perfectly in control of all cases handled. Some most progressive guidance methods have advocated the use of staff conferences on individual cases. In our short-term setup, with four-hour shifts of staff, this has proven to be inconvenient. However, it may have been easier for the administrator. We have found that individual conferences between the case worker and the administrator and his making rounds during treatment hours to be more convenient.

This, of course, puts the final responsibility to a greater degree on the administrator than does the conference method. This does not mean that the individual worker is less free in handling the cases assigned to him. It depends on the way the administrator executes his supervisory task. A conference method is often less free and more autocratic than the administrative supervisory method.

The administrative supervisory method permits quicker and faster action and changes than does the conference form. Conferences can deal less frequently with the same case, and are apt to lead to much more time expenditure for arguments and agreements. If an individual administrator supervises the individual case worker, he still is able to call for conferences between various members if he or the case worker consider this to be of advantage for the progress of the case. On the other hand, the case worker, if in the right spirit, can advance much faster in the therapeutic procedure, if he is not dependent on any conferences, but on the relationship with the administrator alone. The liability of any collaborator of the clinic is larger in this kind of organization.

As to the actual course of treatment, we have never pursued a definite policy. We have left this to the individual worker and his connection with the administrator. For instance, if a change in personal relationships was necessary, this was undertaken without any definite rule. Of course, such policy demands a definite relationship of confidence between the workers and the administrator. This was particularly true in a clinic composed of volunteers. If there was no such relationship between the administrator and the workers, the stay at the clinic was short. During the entire existence of the Beth David Child Guidance Clinic, only one worker dropped out for this reason. There is no doubt that in clinics with paid workers, the collaboration may sometimes drop to the level of paid employment. We believe that only collaboration based upon confidential relationship will work completely satisfactorily in a short-term setting.

We mentioned above the relationship to parents and family. In a majority of cases handled by us, we found it essential for the success of the case to include the family in the treatment of

the child. This part of our work was always the most difficult to bring within the frame of short-term treatment. Many of the children were school referrals, so that a request to see the parents had to be routed through the school. The possibility of having an occupationally active parent withdrawn from even a half a day of wage earning was, in itself, a challenge to the feeling of social responsibility. Usually, it took several weeks to have the parents available on the clinic day. Appointments with the parents were made through the administrator. If this decision had not been made during the admission procedure, we included the family later, when it was deemed essential for the cure of the child. Often one talk with the parent, or important member of the family, helped to clear the way for our purpose. Sometimes a parent was in need of longer social-therapeutic or even psychotherapeutic treatment. We have never made a policy to have such treatment given by the case worker who handled the child. For a time we had someone who was a specialist in working with parents connected with our clinic. On other occasions we felt it best to have the administrator take over such meetings. In any case, there had to be an intimate collaboration between the case worker handling the child and the one handling the parent.

One of the most difficult problems within our short-term setting has been, of course, the problem of when we could terminate treatment in a particular case. Everyone sincere in the effort of psychotherapy knows that the problem of "final cure" is the most irrelevant of all problems of treatment. We need not discuss this here in any detail. However, since our clinic has the features of a dispensary, and with this of a social institution, we had to develop a certain policy regarding the criterion for dealing with each particular child. Of course, we could not accept the old legalistic view, according to which the definition of insanity is that an individual is a danger for himself and society, and that he is cured when "he is again ready for society." In a short-term clinic we cannot accept the concept of cure that demands that all mental suffering of the patient be eliminated. We had to apply, in our clinic, a concept that lies between these two: making sure that the personal relationships of the child to his social environment are so adjusted that he can exist in them without

damage to himself or the environment; but at the same time making sure that the mental or inner status of the child is improved or reinforced to a degree that he does not suffer, but rather starts to enjoy living. We have always attempted to apply positive, rather than negative criteria in regard to the normal life of a child, who if discharged by us, should be on its way to a positive life. Criteria for the evaluation of the cure, have not, I should like to emphasize, been pressed into a dogmatic test by us. Knowledge of health as well as of disease are factors of life existence and not dead formulas. They can, therefore, only be measured and decided by an "alive" sense for their reality.

As an important factor of the pattern of short-term treatment and cure as we have attempted to develop them at the Beth David Child Guidance Clinic, we must define our gradual release and adjustment of the child to normal conditions and environmental healthy relationships, as soon as it is possible to establish them. Cure, for us, is not only a status in the existence of the child, but essentially also, its ability to live in the world in which it is placed. To demonstrate what I mean, I should like to point to the John Little Doe Clinical History on our form. Our reader will see here that we not only "cleaned the inner house" of the boy's mind, but that we also formed outside relations and developed in him relationships to his environment, as soon as this was in any way possible. Inner reconstruction and therapy have to go hand in hand with outside reconstruction of the sound life-relationship. Methods which attempt to do only one or the other will be terribly slow and fail in the essential point of a real cure: speed and efficiency.

What finally concerns the termination of cure and the release of children from our clinic is, as in other matters, decided without formal or dogmatic rule. Since most of our patients paid either no, or merely a nominal fee, financial reasons never played a part. In most cases we, not the patient, terminated the relationship. In almost all cases this termination was a slow or gradual release, except where we had to transfer the case to another agency. After-care treatment or supervision is even more important with children in a short-term setting than otherwise. In most cases where we were dealing with an acute condition, we gradu-

ally increased the time between visits until we saw the patient once every six months. All patients were made to feel free to call on us whenever they felt they needed to do so. We had mentioned above that we had cases which required permanent guidance supervision. We never saw a child more than was deemed necessary, but we also did not release a child before we were sure that the maximum assistance we were able to give had been offered to him.

I would like to devote a paragraph, here at the end, to the problem of frequency of clinical activity. We mentioned above that our clinic operated on a once-a-week basis. I know very well that the majority of present-day psychiatrists and psychotherapists hold that treatment once a week is, in most cases, not enough and hardly successful. There is no doubt in my mind that there are certain types of mental illnesses in which this is perfectly true. It is even truer in the case of younger children, who even in the normal educational procedures need rather frequent repetitions. Particularly in speech therapy and remedial teaching, one hour a week results in terribly slow progress. We had, in these cases, to assume the not too pleasant philosophical attitude of "once a week is better than nothing." We found, however, that in most of the juvenile neurotic states and anything else that fell into the frame of our work, that one visit a week led to the desired fast results. We followed the thesis that, in most cases, efficient and intensive treatment can replace frequency. In those cases where an almost permanent therapeutic influence was necessary, we referred them to other agencies. In rare cases where we thought a second meeting a week was necessary, we found ways to make such arrangements.

Any short-term child-guidance clinic which has two or more workings days a week, has, of course, an advantage over the one-day-a-week clinic, not only in the points discussed above, but also in general efficiency and capacity, as well as in smoother collaboration among the staff. Clinics with more than two-days-a-week service have to be institutions with paid staff, since there are, only in rare instances, efficient workers available who can give more than a limited amount of time for such free services.

THE HARMS-BETH DAVID HOSPITAL CHILD GUIDANCE FORM
NAME: DOE, John Little Address: 100 East 100 St. Ethn. and Rel: Ro. Ca.
Fa. Irish, Mo. Dutch.

BIRTH DATE AND PLACE: Jan. 1, 1934. New York. Applicant: Principal
P.S. 500.

MOTHER: Mary—cleaningwoman—partly relief.

FATHER: John—alcoholic—whereabouts unknown.

SIBLINGS: g. 23 married; b. 21 working, supports; b. 19 accidental death; b. 18; g. 17; miscarriage.

RELATIVES: father's only sister in mental hospital; in mother's family T.B.

PRENATAL, NATAL FACTS, FIRST THREE YEARS: since mother unwilling to come to clinic, no information yet.

CHILDREN'S DISEASES, and Other Dis.: (Boy's own recollection) meas., chickp., tons. in, pn. at age 4 and 8—hosp. at second.

EDUCATIONAL AND SCHOOL HISTORY: irregular in P.S.; now in P.S. 500—7B.

PHYSICAL EXAMINATION: Anemic appearance—Physically neglected—EENT: neg.—except carious teeth—Chest, Heart: Neg.—Some fine rales at left apex—Anterior: No dullness to percussion—Abdomen: no masses or tenderness—no Hernias—Neurological: increased reflexes.

COMPLAINTS: Dizzy spells & Headaches.

X.Z. pediatrician M.D.

TESTS: Chest X-ray—neg.; T.B. test—neg.; Dentist—Neurological—nothing essential.

SOCIAL EXAMINATION: 3 rooms, sleeps with bro. in one bed; Mo. & sisters sleep in other room. Cinderella type of youth, pushed around and ill treated by older sibs. Undernourished. Nailbiter. In a juvenile state of desperation, no comradeship besides being used by older boys for all kinds of services. Hates everyone. Used gutter language in waiting room in attempt to show off, since he did not succeed spit in boy's face. States "that he would like to learn and be a doctor but teacher never liked him."

SCHOOL REPORT: frequent truant, dresses & smells so badly that others refuse to sit with him, unruly, bad manners, answers back, cries easily, takes from classmates and others anything he can lay hands on (never caught stealing by police).

DOCUMENTS:

PSYCHOLOGICAL EXAMINATION: Neurasthenic, not actually mentally retarded boy. Retardation mainly caused by educational neglect. Artificially extroverted and ego-inflated daydreamer. I.Q., conditioned evaluation 83. Reading ability about 3rd grade. Hardly fully matured, but mastr. excessively, bed-wetter, restless sleeper with nightmares. Believes to be able to do everything & cannot do anything. Highly appreciative for any sign of warmth and love and becomes infantile through them.

TESTS:

BETH DAVID HOSPITAL—CHILD GUIDANCE CLINIC FORM (cont'd)

PSYCHIATRIC EXAMINATION AND CASE EVALUATION: Schizoid personality type with slight, however not firmly established, forms of behavior disorder. *Pavor nocturnus* and strongly entrenched human-phobic trends. More reeducational adjustment than psychiatric help needed.

CLINICAL HISTORY: Jan. 3—Physical examination—X-ray. T.B. & appointment with Neurol. Inst. ordered. Request for mother—no decision on psychotherapy as yet.

Jan. 10—Mother refuses visit to clinic. T.B. neg. Boy given by Adm. to Miss A.B. for remedial reading test aso. First Psychotherap. approach. Adm.

Jan. 17—X-ray neg. Had been at Neurol. Inst. Rem. reading given. He starts eagerly, but drops off within a few minutes—produced fantastic stories about friends and family—tells dream of being thrown from window by bro. but saved by Superman. Drawing test shows basic hostility against family and school. A.B.

Jan. 24—Absent from clinic.

Jan. 31—Had been sent to clinic last time, but played truant. He responds with freshness & lies when questioned about absence. No rem. reading poss. Psychotherapy given by attempting to give him aim & trust in us. A.B. & Admin.

Feb. 7—Has responded to psychotherap. Comes with drawings he had done at home. Has clean hands. We promise new clothes and joining of after-school club if he keeps up. Had fight with some boys after treatment because he offended one. A.B.

Feb. 14—Report from Neurol. Inst. essentially neg. Build-up medicine given by pediatrician. Responds slowly to remedial training. Therapeutic approach more successful. May soon be ready to have him join a boys' club. Pediatrician, A.B. Adm.

Feb. 21—Got new clothes. School reports improvement. Responds better to remedial lesson. Request thru school older sister to visit clinic. Made arrangement with boys' club. Psychotherapy reveals great deal of bad dream material—great deal of insecurity, fears, and hate. A.B. Adm.

Mar. 1—Sister receives advice on how to handle boy at home, tells of his better behavior recently. Was away from school 2 days again, clash with teacher. Discuss matter of his handling with school & give suggestions. Remedial response good. "He likes this teaching better than that in school because he gets made clear what its all about." Beams about first session at boys' club. Psychotherapy directed to have him accept bad elements of old & earlier environment, along with the new sphere of existence into which we have slowly transplanted him. Nightmares & violent hostility against home & school. A.B. Adm.

Mar. 8—At door of clinic before it opens, beaming, reporting that he won prize at boys' club. He oversteps with hopes & plans all his measures and our psychotherapy has to work on correction of these features. Remedial response good. A.B.

Mar. 15—Sick, hurt foot in accident at boys' club gym. A.B.

Mar. 22—Wrote postal card to us telling he was unable to come last time. Comes limping this time. Hysterical traumatic features & receives long psychotherapy. Response to remedial work not too good. A.B. Adm.

Mar. 29—Had lots of trouble at home during sickness. Features resentment again at boys at the club—result of his accident. Asks us to get him music lessons, probably because another boy had those—speaks of future plans and occupational concepts far more realistic than earlier. Response to remedial work satisfactory. Great deal of hostility against school and home. Therapy attempt to suppress the growing negative emotions against new sphere espec. boys' club. Also work on sleep and dream conditions. New Physical given no essential new findings. A.B. Adm. Pediatrician.

April 5—School report better—back to normal living and good relationships in boys' club. Home relationships also better. Had to whittle down some of his inflated plans which we replaced with realistic ones. Response to remedial training good. A.B.

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